End User Training for Fee-for-Service Process

ProviderConnect

September 2014

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Introduction to IBHIS for Fee-for-Service Providers

Overview

- Integrated Behavioral Health Information System (IBHIS) is the new electronic Health Record System (EHRS) that is implemented by Los Angeles County Department of Mental Health (LACDMH).

- ProviderConnect is a web interface to communicate with IBHIS.

- ProviderConnect is a standard browser based application and can be launched from any web browsing application such as Internet Explorer, Chrome, or Firefox.

- ProviderConnect has real time communication with IBHIS and hence any information submitted is directly entered/updated into the IBHIS system immediately.

- Fee-For-Service (FFS) outpatient providers will use ProviderConnect to:

  - Search for a client

  - Add a new client and create a FFS outpatient admission

  - Edit the client demographic information

  - Complete the client's CSI Admission

  - Complete the client's financial eligibility

  - Complete the client's pregnancy status, if applicable

  - Request over-threshold authorizations

  - Attach supporting documentation to over-threshold authorization requests

  - View the attached documents

  - Check status of authorization requests, and view the authorization response from the Central Authorization Unit (CAU)

  - View the Notice of Actions (NOA) if any.

Access and Limitations

- In order to access the system, you will be provided with a web address (URL- Uniform Resource Locator) which will be used to launch the browser based application.

- Each user must complete the following forms to attain a ProviderConnect user ID and password: 1) Application Access Form; 2) Oath of Confidentiality; 3) E-Signature Agreement; 4) County of LA Agreement for Acceptable Use. The forms are posted on the IS website via the following link and must be submitted to LACDMH for processing: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Forms.htm. Once your request is approved, a user ID and password will be issued to you by LACDMH. The initial password that is provided must be changed upon the first login to the system.

- ProviderConnect allows you to upload supporting documentation to support the authorization request. The upload file size is limited to 1MB (Mega Byte). If the size of the file is large, you will have to split the document to the multiple files each with the size of 1MB.

- Once an authorization request is submitted via ProviderConnect, you will not be able make any changes in the submitted request. If necessary, you will have to contact CAU to deny your application and then submit a new request.

- ProviderConnect does not verify Medi-Cal eligibility for clients. Client Medi-Cal eligibility must be verified via the state Medi-Cal website, or the Automated Eligibility Verification System, or a Point of Service Network Device.

- ProviderConnect does not process claims for services. Providers must submit all claims via EDI.

LACDMH Contact Information

- CAU Contact Phone Number: (213) 738-2466

ProviderConnect Workflow for FFS Providers

Login

Main Menu

Main Menu:
Add New Client /
Client Search

Search Results

Sought
Client on
List?

Yes

No

Click on
Client ID
link

Client Task Bar:
Provider
Admissions

Episode Information

Is there an
Admission under
the generic FFS-
Legal Entity?

No

Yes

Button:
Create Admission
for New Client

Episode Information

Is there an
Admission under the
generic FFS-Legal
Entity?

No

Button:
Add Admission
Record

Yes

Client Task Bar:
Select Menu Item
for desired action.

Demographic

Authorization

Overthreshold
Authorization
Request

Attachments

ProviderConnect Exercises: Sign In, Set Password & Main Menu

Overview
This exercise will demonstrate the user how to log in to ProviderConnect, how to set up a new password during the initial login process, and how to access the Main Menu in ProviderConnect.
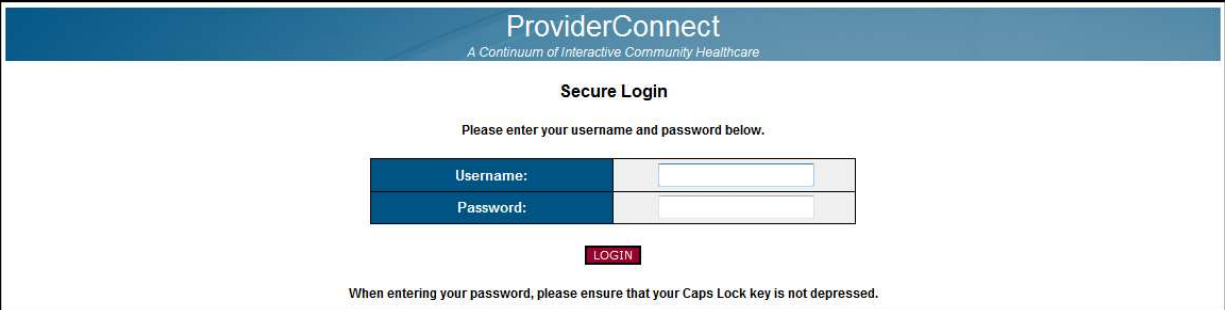
Training Exercise: Sign In, Set Password, News, and Main Menu

1. The ProviderConnect live and test environments can be accessed via the links:
   - LIVE ENVIRONMENT: https://lapconn.netsmartcloud.com/la/login.asp
   - TESTING ENVIRONMENT: https://lapconn.netsmartcloud.com/laSBOX/login.asp
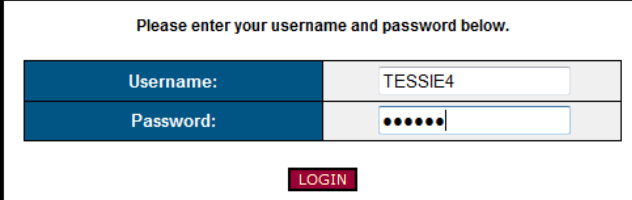
NOTE: The live environment is to be used only by users that have passed claims testing and are fully trained on ProviderConnect. For purposes of claims testing, training, and practice, please use the testing environment.

2. To sign-in to ProviderConnect, you will be presented with the Secure Login form.

3. Enter your User Name and the password supplied to you.

4. Follow the on screen instructions about creating a new password to complete the login process.

5. The confidentiality message configured in the system.   Click "Continue."

6. …and news for users from system administrators if any. Click "Skip to Main Menu."

7. The Provider Connect – Main Menu

ProviderConnect Exercises: Main Menu and Navigation

Overview
This exercise will demonstrate the user how to navigate the Main Menu and Quick Menu in ProviderConnect.

Training Exercise: Using the Main Menu & Quick Menu

1. Access the Main Menu; examine the form and the selections.

Status Bar: 'quick menu'

Status bar & 'quick menu' is available on all forms. Use these items to jump to *Lookup Client, Main Menu* or to Log Out at any time.

➢ Note that the form you are on will <u>not be saved</u>.

➢ *The Provider Connect – Main Menu may vary depending upon your user profile.*
Provider Connect Main Menu items:

Menu Item	Function
Lookup Client	Launches a lookup form to search for clients assigned to your provider. This form is commonly used first.
Add New Client/Client Search	Launches a search criteria form that searches client's records in Avatar. If a record is found and selected, the user may proceed to demographic, authorization and treatment forms about this client in Provider Connect
Change Password	Launches the *Change Password* form
Documentation	Open the Provider Connect Documentation
News	Returns you to the *News* display
Logout / Exit	Logs you out of Provider Connect

ProviderConnect Exercises: Searching for Clients

Overview

This exercise will demonstrate the user how to search for existing clients and verify if incoming clients already exist in the system through the use of the Lookup Client feature and the Client Search feature. ProviderConnect has two distinct client search features. The Client Search feature allows you to generate a search for all clients that exist in IBHIS, whereas the Lookup Client feature allows you to generate a search only for clients that were created by your agency via ProviderConnect, or clients for which your agency has created an authorization request in ProviderConnect.

The search feature(s) that you must use is dependent upon whether or not the client has been established in ProviderConnect. Providers should use the Client Search feature to generate a search for brand new clients. Once the client's admission has been created in ProviderConnect by your agency, or once your agency has created an authorization request for the client, you may use the Lookup Client feature to search for the client's record. In other words, use the Client Search feature to search for brand new clients that your agency has never treated before, and use the Lookup Client feature to search for clients that your agency is currently providing treatment for or clients that have been treated by your agency in the past.

Training Exercise: Using the Lookup Client Feature and the Client Search Feature to Search for New Clients with No Existing Client Record

1. From the Main Menu or the Quick Menu, click on *Lookup Client* to access the Lookup Client search feature.

ProviderConnect - Main Menu		SCHMIDT,JILL 3/5/2014 1:42:50 PM Look
You are logged in as:	JSCHMIDT	
Your last login was:	3/5/2014 1:41:00 PM	

Main Menu - Provider		
Lookup Client	**Add New Client/Client Search**	**Change Password**
Documentation	**News**	

Logout / Exit

About ProviderConnect v2.188.4

2. The Lookup Client form will appear. Enter the client's information (social security number, first name, last name, and date of birth), and click *Search by Criteria*.

Search Criteria	
Member ID:	
SSN:	987-44-4444
First Name:	ONE
Last Name:	TWO
Date of Birth:	1/30/1995
Agency:	SCHMIDT, JILL E.

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

Back

3. As you can see from the search results, in this scenario the client was not found using the Lookup Client search feature. If the client's record cannot be found using the Lookup Client search feature, it is a clear indicator that the client does not have an existing authorization request with your agency. However, this does not indicate that the client does not have an existing client record with another provider or DMH facility. You must use the Client Search feature as well to make sure that the client does not have an existing client record in IBHIS. Navigate back to the Main Menu using the Quick Menu.

ProviderConnect - Look Up Client   SCHMIDT, JILL E. 6/16/2014 10:24:51 AM   Lookup Client | Main Menu | Log Out

Search Results				
Client ID	Last Name	First Name	Date of Birth	Agency
		Client not found		

Search Criteria

Back

4. From the Main Menu, click *Add New Client/Client Search* to access the Client Search feature.

ProviderConnect - Main Menu   SCHMIDT,JILL 3/5/2014 1:42:50 PM   Look

You are logged in as:	JSCHMIDT
Your last login was:	3/5/2014 1:41:00 PM

Main Menu - Provider		
Lookup Client	Add New Client/Client Search	Change Password
Documentation	News	

Logout / Exit

About ProviderConnect v2.188.4

5. The Client Search form will open.

Search Criteria	
Social Security Number:	
Last Name:	
First Name:	
Sex:	⬤ Female - F ⬤ Male - M ⬤ Other - O ⬤ Unknown - U *
Date of Birth:	

Search

Back

About ProviderConnect v2.188.4

6. Enter the client's information, and click *Search.* (Red fields indicate that the information is required.)

Search Criteria	
Social Security Number:	987-44-4444
Last Name:	TWO
First Name:	ONE
Sex:	⦿ Female - F ⬚ Male - M ⬚ Other - O ⬚ Unknown - U
Date of Birth:	01/30/1995

Search

Search Results					
ID	Name	Date Of Birth	Client's Address City	Alias	Score
1001120	AVENUE,STREET	04/04/2009	Los Angeles		120

Create Admission for New Client

7. As you can see from the search results, the client was not found using Client Search as well. If the client's record cannot be found using the Client Search feature, it is a clear indicator that the client does not have an existing client record in IBHIS, and therefore, does not have an existing client record with another provider or DMH facility.

8. Being that this client does not have an existing client record in IBHIS, you will need to create the client's record and an admission for the client, as further explained in ProviderConnect Exercises: Creating an Admission for the Client.

Training Exercise: Using the Lookup Client Feature to Search for Your Existing Clients

1. From the Main Menu, click on *Lookup Client* to access the Lookup Client search feature.

ProviderConnect - Main Menu		SCHMIDT,JILL 3/5/2014 1:42:50 PM Look

You are logged in as:	JSCHMIDT
Your last login was:	3/5/2014 1:41:00 PM

Main Menu - Provider		
Lookup Client	Add New Client/Client Search	Change Password
Documentation	News	

Logout / Exit

About ProviderConnect v2.188.4

2. The Look Up Client form will appear.

Search Criteria	
Member ID:	
SSN:	
First Name:	
Last Name:	
Date of Birth:	
Agency:	SCHMIDT,JILL

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

Back

3. Enter no criteria and click *Search by Criteria.*

Search Results				
Client ID	Last Name	First Name	Date of Birth	Agency
1001117	DOWN	UP	1/1/2005	SCHMIDT,JILL
1001118	RIGHT	LEFT	2/2/2005	SCHMIDT,JILL
1001119	SAD	HAPPY	3/3/2000	SCHMIDT,JILL
1001120	AVENUE	STREET	4/4/2009	SCHMIDT,JILL
1001121	COMPUTER	PRINTER	5/5/2005	SCHMIDT,JILL
1001124	PENCIL	PEN	6/15/2004	SCHMIDT,JILL
1001125	STAPLE	PAPER	7/31/2003	SCHMIDT,JILL
			8/21/2002	SCHMIDT,JILL
			9/12/2002	SCHMIDT,JILL
			10/5/2006	SCHMIDT,JILL
			11/11/2004	SCHMIDT,JILL
			12/20/2005	SCHMIDT,JILL

Notice that these search results have the blue link on the clients' IDs. If you click on the client's ID, the client's Demographic form will open.

NOTE: ProviderConnect will generate a search for every client that was created via ProviderConnect by your agency, or any client that has an existing Over-threshold authorization request with your agency.

4. Click *Lookup Client* on the Quick Menu, or click *Back* at the bottom of the screen, to open the Lookup Client form.

5. The Lookup Client form appears again. This time, enter the client's criteria and click *Search*.

Search Criteria	
Member ID:	3000725
SSN:	987-00-0066
First Name:	PURPLE
Last Name:	RAIN
Date of Birth:	6/1/1990
Agency:	SCHMIDT, JILL E.

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

Back

6. As you can see by the search results, this client has an existing record in ProviderConnect, meaning that your agency created the client's record and admission, or has an existing authorization request with your particular agency. Click on the client's *ID* number.

Search Results				
Client ID	Last Name	First Name	Date of Birth	Agency
3000725	RAIN	PURPLE	6/1/1990	SCHMIDT, JILL E.

Notice that these search results have the blue link on the clients' IDs. If you click on the client's ID, the client's Demographic form will open.

Search Criteria

Back

7. Click on the *Client ID* number in order to access the client's record in ProviderConnect.

NOTE: In general, blue links such as the Client ID here will open a new more detailed form.

8. The client's Demographic form will appear. Verify the client's demographic information, such as client name, social security number, date of birth, sex, ethnicity, address, and phone numbers, to ensure that this is the correct client.

Member ID		
3000725		

Client Condition - Pregnancy	
Demographic	
CSI Admission	
Financial Eligibility	
Authorizations	
Provider Admission	
Provider Diagnosis	
Attachments	
Day Treatment / MHS Authorization Details	
DCFS Status Tracking	
Over Threshold Authorization Request	
Public Guardian Status Tracking	
Systemwide Annual Liability	
Exit to Main Menu	

ProviderConnect - Demographic   SCHMIDT, JILL E. 3/19/2014 4:05:50 PM   Lookup Client | Main Menu

Client Name: RAIN, PURPLE
Member ID: 3000725
SSN: 987-00-0066

Member Demographics

Social Security Number 987-00-0066	Date of Birth 6/1/1990	Facility Chart Number
Member Street 1 1000 1ST STREET	Member Street 2 APT 8	Member City LOS ANGELES
Member County Los Angeles - 19		Member State CA - CALIFORNIA
Member Zip Code 90012	Member Phone Number 323-555-5555	Member Work Number 231-777-7777
Member Language English - 7	Sex Female - F	Race African-American - 2 American Indian/Alaska Native - 4 Armenian - 31 Asian Indian - 15
Client Maiden Name SMITH	Veteran	Education Level At Admission Associate of Arts degree - 18
Citizenship Status -Please Choose One-	Pre-Admission Disposition	
Employment Status Full-time competitive employment (salaried) - FC		
Marital Status Now Married (Includes Common-Law) - 2	Client's Cell Phone 323-999-9999	Client's Email Address purplerain@yahoo.com
Communication Preference Cell Phone - 5	Smoker Never Smoked - 3	Client Declined to Provide Information Ethnic Origin - 8 Language - 149 Race - 116

9. Once the client's demographic information is verified, click *Provider Admission* in the task bar to open the Provider Admission form. As you can see, this client has an existing FFS2 admission that was created on 3/12/2014. Click on the Admission Date to open the admission.

Member ID		
3000725		

Client Condition - Pregnancy	
Demographic	
CSI Admission	
Financial Eligibility	
Authorizations	
Provider Admission	
Provider Diagnosis	
Attachments	
Day Treatment / MHS Authorization Details	
DCFS Status Tracking	
Over Threshold Authorization Request	
Public Guardian Status Tracking	
Systemwide Annual Liability	
Exit to Main Menu	

ProviderConnect - Provider Admissions   SCHMIDT, JILL E. 3/19/2014 4:16:06 PM   Lookup Client | Main Menu | Log Out

Client Name: RAIN, PURPLE
Member ID: 3000725
SSN: 987-00-0066

Episode Information

Episode	Admission Date	Discharge Date	Program
1	3/12/2014	Create Discharge	x FFS2LE Fee For Service 2 Admission

Add Admission Record

NOTE: Existing Provider Admission forms can only be opened if the particular admission was created by your agency. If the system allows you to open the admission for the client, as described in the next step, it is a clear indicator that the admission was created by your agency.

10. The Admission Form will open and display the detailed information for that particular FFS2 admission, including the admission date and time, the type of admission, and the admitting practitioner. As you can see, this admission was created by your agency.

Member ID	
3000725	

ProviderConnect - Provider Admission Form	SCHMIDT, JILL E. 3/19/2014 4:17:46 PM	Lookup Client	Main Menu	Log Out

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

Day Treatment / MHS Authorization Details
DCFS Status Tracking
Over Threshold Authorization Request
Public Guardian Status Tracking
Systemwide Annual Liability

Exit to Main Menu

Back

Client Name:	RAIN, PURPLE
Member ID:	3000725
SSN:	987-00-0066

Admission Information

Episode Number	Client Name
1	RAIN,PURPLE
Sex (X) Female - F ( ) Male - M ( ) Other - O ( ) Unknown - U	
Date of Birth 6/1/1990	**Age** 23
Admission Date 3/12/2014	**Admission Time** 10:02 AM
Program x FFS2LE Fee For Service 2 Admission	**Admitting Practitioner** SCHMIDT,JILL
Attending Practitioner	**Type of Admission** First Admission - 1
Source of Admission	**Social Security Number** 987-00-0066
Alt Social Security Number	**Advanced Directive** ( ) No - N ( ) Yes - Y
Advanced Directive Note	

Demographics

Client Home Phone Number 323-555-5555	Client Work Number 231-777-7777
Client Address Line 1 1000 1ST STREET	Client Address Line 2 APT 8
Client Address - City LOS ANGELES	Client Address - State CA - CALIFORNIA

Training Exercise: Using the Client Search Feature to Search for New Clients with Existing Admissions to Other FFS Providers

1. From the Main Menu or the Quick Menu, click on *Lookup Client* to access the Lookup Client search feature.

ProviderConnect - Main Menu		SCHMIDT,JILL 3/5/2014 1:42:50 PM	Look

You are logged in as:	JSCHMIDT
Your last login was:	3/5/2014 1:41:00 PM

Main Menu - Provider		
Lookup Client	Add New Client/Client Search	Change Password
Documentation	News	

Logout / Exit

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2. The Lookup Client form will appear. Enter the client's information (social security number, first name, last name, and date of birth), and click *Search by Criteria*.

Search Criteria	
Member ID:	
SSN:	987-11-2222
First Name:	CALM
Last Name:	PATIENT
Date of Birth:	2/1/1991
Agency:	SCHMIDT, JILL E.

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

Back

3. As you can see from the search results, in this scenario the client was not found using the Lookup Client search feature. If the client's record cannot be found using the Lookup Client search feature, it is a clear indicator that the client does not have an existing authorization request with your agency. However, this does not indicate that the client does not have an existing client record with another provider or DMH facility. You must use the Client Search feature as well to make sure that the client does not have an existing client record in IBHIS. Navigate back to the Main Menu using the Quick Menu.

ProviderConnect - Look Up Client		SCHMIDT, JILL E. 6/16/2014 10:24:51 AM	Lookup Client	Main Menu	Log Out

Search Results				
Client ID	Last Name	First Name	Date of Birth	Agency
Client not found				

Search Criteria

Back

4. From the Main Menu, click on *Add New Client/Client Search*.

ProviderConnect - Main Menu		SCHMIDT,JILL 3/5/2014 2:04:42 PM	Lookup C

You are logged in as:	JSCHMIDT
Your last login was:	3/5/2014 1:41:00 PM

Main Menu - Provider		
Lookup Client	Add New Client/Client Search	Change Password
Documentation	News	

Logout / Exit

5. The Client Search form will open.

Search Criteria	
Social Security Number:	
Last Name:	
First Name:	
Sex:	Female - F Male - M Other - O Unknown - U *
Date of Birth:	

Search

Back

6. Enter the client's criteria again, and click *Search*. Keep in mind that the more information you provide when generating client searches, the more accurate your search results will be. (Red fields indicate that the information is required.)

Search Criteria	
Social Security Number:	987-11-2222
Last Name:	PATIENT
First Name:	CALM
Sex:	○ Female - F ● Male - M ○ Other - O ○ Unknown - U
Date of Birth:	02/01/1991

Search

Search Results							
ID	Name	Date Of Birth	Client's Address City	Client's Address Zipcode	Alias	Admitting Practitioner	Score
3000628	PATIENT,CALM	02/01/1991	Los Angeles	90001	SAM	156698	231

Create Admission for New Client

Back

Notice that these search results also have the blue link on the clients' IDs. If you click on the client's ID, the client's Demographic form will open.

NOTE: As you can see from the search results, the client record appears to exist in Avatar MSO. Verify that this is the correct client by viewing their demographic information via the

following steps. If two or more clients with similar name and date of birth are listed, please make sure that you identify the right client by verifying their information via the following steps.

7. Click on the *Client ID* number in order to access the client's record in ProviderConnect.

NOTE: In general, blue links such as the Client ID here will open a new more detailed form..

8. The Provider Admission form will appear. Verify if the client has an open FFS2 admission (x FFS2LE Fee For Service 2 Admission). As you can see, this client has an active FFS2 admission. Notice that in this case, the system does not allow you to open the admission for the client, as with the previous training exercise. This is a clear indicator that the admission was created by another FFS2 provider. Also, notice that this particular client has an open admission with Tessie Cleveland Community Services and an LA County DMH directly-operated clinic.

Member ID
3000628

| Client Condition - Pregnancy |
| Demographic |
| CSI Admission |
| DCFS Status Tracking |
| Financial Eligibility |
| Public Guardian Status Tracking |
| Authorizations |
| Provider Admission |
| Provider Diagnosis |
| Attachments |

| Day Treatment / MHS Authorization Details |
| Over Threshold Authorization Request |
| Systemwide Annual Liability |

| Exit to Main Menu |

ProviderConnect - Provider Admissions   SCHMIDT, JILL E. 6/16/2014 11:24:23 AM   Lookup Client | Main Menu | Log Out

Client Name:	PATIENT, CALM
Member ID:	3000628
SSN:	987-11-2222

Episode Information

Episode	Admission Date	Discharge Date	Program
3	6/9/2014		LE01379 Tessie Cleveland Comm Srvc Corp
2	1/10/2014		x FFS2LE Fee For Service 2 Admission
1	11/30/2013		LE00019 LA County DMH

Add Admission Record

NOTE: The client must have an active admission with a FFS provider before you can move forward to complete the Financial Eligibility forms and create an authorization request for Over-threshold services. All FFS providers will use the same admission to create the authorization request for the client. If the client already has an existing FFS2 admission, as illustrated in the example above, and the client is being treated by you for the first time, another FFS provider could possibly be treating the client. If another FFS provider is proving treatment to the client, your under-threshold and over-threshold claims might be impacted. Please verify with the client whether or not he or she has received treatment from another FFS provider during the current trimester period.

9. Now, click *Demographics* on the task bar.

10. The Demographics form will appear. Verify that the client's demographic information, such as client name, social security number, date of birth, sex, ethnicity, address, and phone numbers, is accurate.

Client Name:	PATIENT, CALM
Member ID:	3000628
SSN:	987-11-2222

Member Demographics

Social Security Number 987-11-2222	**Date of Birth** 2/1/1991	**Facility Chart Number**
Member Street 1 99 1ST STREET	**Member Street 2** APT 1	**Member City** Los Angeles
Member County Los Angeles - 19		**Member State** CA - CALIFORNIA
Member Zip Code 90001	**Member Phone Number** 323-555-5555	**Member Work Number** 323-777-7777
Member Language English - 7	**Sex** Male - M	**Race** African-American - 2 American Indian/Alaska Native - 4 Armenian - 31 Asian Indian - 15
Client Maiden Name	**Veteran**	**Education Level At Admission** Associate of Arts degree - 18
Citizenship Status -Please Choose One-	**Pre-Admission Disposition**	
Employment Status Part-time competitive employment (salaried) - PC		
Marital Status Single / Never Married - 1	**Client's Cell Phone** 323-666-6666	**Client's Email Address** calmpatient@yahoo.com
Communication Preference Cell Phone - 5	**Smoker** -Please Choose One-	**Client Declined to Provide Information** Ethnic Origin - 8 Language - 149 Race - 116

Save Record

NOTE: If you try to search for this client under the Lookup Client feature, as explained in this training exercise, you will notice that the client will not show up in your search results. When a client has an existing FFS2 admission and his record shows up under the Client Search feature but does not show up under the Lookup Client feature, it is a clear indicator that the existing FFS2 admission for that client was created by another FFS provider.

11. Being that this client has an active FFS2 admission, once the client information is verified, you may move forward to ProviderConnect Exercises: Completing Financial Eligibility for the Client.

ProviderConnect Exercises: Editing Client's Demographic Information

Overview

This exercise will demonstrate the user how to edit the client's demographic information, using the Demographic form.

The client's demographic information may only be changed if the client has an existing FFS2 admission. Please note that the client's name, date of birth, and social security number cannot be edited in the ProviderConnect. Changes to such information, and any other information that cannot be edited, will require you to contact CAU. Before making such a request to CAU, please be absolutely sure that you have opened the correct client record.

Training Exercise: Using the Demographics Form to Edit Client's Information

1. Click Demographic on the task bar to open the Demographic form for the client.

Member ID		ProviderConnect - Demographic		SCHMIDT, JILL E. 3/21/2014 2:59:12 PM	Lookup Client	Main Menu
3000725						

Client Name:	RAIN, PURPLE
Member ID:	3000725
SSN:	987-00-0066

Task bar:
- Client Condition - Pregnancy
- Demographic
- CSI Admission
- Financial Eligibility
- Authorizations
- Provider Admission
- Provider Diagnosis
- Attachments
- Day Treatment / MHS Authorization Details
- DCFS Status Tracking
- Over Threshold Authorization Request
- Public Guardian Status Tracking
- Systemwide Annual Liability
- Exit to Main Menu

Member Demographics

Social Security Number	Date of Birth	Facility Chart Number
987-00-0066	6/1/1990	

Member Street 1	Member Street 2	Member City
1000 1ST STREET	APT 8	LOS ANGELES

Member County		Member State
Los Angeles - 19		CA - CALIFORNIA

Member Zip Code	Member Phone Number	Member Work Number
90012	323-555-5555	231-777-7777

Member Language	Sex	Race
English - 7	Female - F	African-American - 2 / American Indian/Alaska Native - 4 / Armenian - 31 / Asian Indian - 15

Client Maiden Name	Veteran	Education Level At Admission
SMITH		Associate of Arts degree - 18

Citizenship Status	Pre-Admission Disposition	
-Please Choose One-		

Employment Status		
Full-time competitive employment (salaried) - FC		

Marital Status	Client's Cell Phone	Client's Email Address
Now Married (Includes Common-Law) - 2	323-999-9999	purplerain@yahoo.com

Communication Preference	Smoker	Client Declined to Provide Information
Cell Phone - 5	Never Smoked - 3	Ethnic Origin - 8 / Language - 149 / Race - 116

Save Record

NOTE: Please be absolutely sure that you have opened the correct client record before making any changes to the client's demographic information.

2. Edit the client's cell phone number, employment status, and marital status.

3. Click *Save Record* to save your changes.

ProviderConnect Exercises: Creating the Client Record and Creating an Admission for the Client

Overview

This exercise will demonstrate the user how to create the client record for a client that does not currently exist in IBHIS. As part of the process for creating the client record, the user must create a Fee-for Service 2 admission for client, using the Admission form. Both the client record and the admission for the client will be created during this one-step process, and it should only be created once to avoid duplicate client records and admissions. FFS2 admissions will remain open for the lifespan of the client and should only be closed in the event that the client is deceased. Once a Fee-for-Service provider creates the client record and FFS2 admission, the same client record and admission may be used by other Fee-for-Service providers to create and submit Over-threshold Authorization Requests for that particular client and submit claims via EDI, which emphasizes the importance of thoroughly searching for the client in ProviderConnect to avoid creating duplicate client records and FFS2 admissions. Please make sure that you thoroughly search for the client in ProviderConnect, as explained in previous training exercises, before creating the client record and FFS2 admission for the client.

A FFS2 admission must exist in the client record in order to move forward and complete the Systemwide Annual Liability form, Financial Eligibility form, and create an Over-threshold Authorization Request form for services, which are explained in the next training exercises.

Training Exercise: Using the Admission Form to Create a Client Record and a FFS2 Admission

1. After searching for the client via the Search Client feature, click *Create Admission for New Client*.

Search Criteria	
Social Security Number:	987-44-4444
Last Name:	TWO
First Name:	ONE
Sex:	○ Female - F ● Male - M ○ Other - O ○ Unknown - U
Date of Birth:	01/30/1995

Search

No clients found.

Create Admission for New Client

Back

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2. The Admission form will open. Any information that was entered during your search will prepopulate the Admission form. (Red fields and red asterisks indicate that the information is required.)

| Back | ProviderConnect - Provider Admission Form | | SCHMIDT, JILL E. 5/7/2014 2:06:01 PM | Lookup Client | Main Menu | |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Admission Information

Sex
◉ Female - F ◯ Male - M ◯ Other - O ◯ Unknown - U

| **Date of Birth** | **Age** |
| 01/30/1995 | 19 |

| **Admission Date** | **Admission Time** |
| | *HH:MM AM/PM* |

| **Program** | **Admitting Practitioner** |
| --Please Choose One-- ▾ * | --Please Choose One-- ▾ * |

| **Attending Practitioner** | **Type of Admission** |
| --Please Choose One-- ▾ | -Please Choose One- ▾ * |

| **Source of Admission** | **Social Security Number** |
| -Please Choose One- ▾ | 987-44-4444 |

| **Alt Social Security Number** | **Advanced Directive** |
| | ◯ No - N ◯ Yes - Y |

Advanced Directive Note

Demographics

Client Last Name	**Client Home Phone Number**
TWO	
Client First Name	**Client Work Number**
ONE	

3. Complete the Admission Information. Enter the Admission Date and Admission Time. Select "x FFS2LE Fee For Service 2 Admission" from the Program drop down, select your name from the Admitting Practitioner drop down, and select Elective from the Type of Admission drop down.

Admission Information	
Sex ○ Female - F ● Male - M ○ Other - O ○ Unknown - U	
Date of Birth 01/30/1995	**Age** 19
Admission Date 03/07/2014	**Admission Time** 8:30 AM *HH:MM AM/PM*
Program x FFS2LE Fee For Service 2 Admission ▼	**Admitting Practitioner** SCHMIDT,JILL ▼
Attending Practitioner --Please Choose One-- ▼	**Type of Admission** Elective - 5 ▼
Source of Admission -Please Choose One- ▼	**Social Security Number** 987-44-4444
Alt Social Security Number	**Advanced Directive** ○ No - N ○ Yes - Y
Advanced Directive Note	

NOTE: Please be sure to enter the correct admission date and admission time for the client. The admission date and time cannot be changed once the Admission form is saved and submitted.

4. Complete the Demographics section as accurately as possible.

Demographics	
Client Last Name TWO	**Client Home Phone Number**
Client First Name ONE	**Client Work Number**
Client Address Line 1 1000 1ST STREET	**Client Address Line 2** APT 8
Client Address - City LOS ANGELES	**Client Address - State** CA - CALIFORNIA
Client Address - Zip Code 90012	**Client Address - County** Los Angeles - 19
Marital Status Single / Never Married - 1	**Race/Ethnicity** Unknown/Not Reported - 99 Vietnamese - 19 West African - 27 White - 1
Education Associate of Arts degree - 18	**Religion** Agnostic - 26
Other Ethnic Origin Field not yet supported	**Place of Birth** DOWNEY
Citizenship -Please Choose One-	**Country of Origin** United States - US
Maiden Name	**Occupation** Administrative Support Occupations Including Clerical - 5
Client's Primary Language English - 7	**Informed of Smoking Policy** ○ No - N ⦿ Yes - Y
Employment Status Full-time competitive employment (salaried) - FC	
Alias SAM	**Alias 2**
Alias 3	**Alias 4**
Alias 5	**Alias 6**
Alias 7	**Alias 8**
Alias 9	**Alias 10**
Client's Cell Phone 323-333-3333	**Client's Email Address** onetwo@yahoo.com
Communication Preference Cell Phone - 5	**Smoker** Never Smoked - 3
Client Declined to Provide Information Ethnic Origin - 8 Language - 149 Race - 116	

Save Admission

Cancel

5. Click *Save Admission* at the bottom of the Admission form.

NOTE: Before you click *Save Admission*, please make sure that you have entered the correct admission date and admission time for the client. You will not be able to edit the client's admission date and time once you click *Save Admission*. In the event that you need to change the client's admission date or admission time, please contact the Central Authorization Unit at (213) 639-6344.

6. You will be returned to the Main Menu.

7. Once the FFS2 admission is created, you may proceed to ProviderConnect Exercises: Completing the CSI Admission for the Client.

ProviderConnect Exercises: Completing the CSI Admission for the Client

Overview

This exercise will demonstrate the user how to complete the CSI Admission for the client, using the CSI Admission form.

Training Exercise: Using the CSI Admission Form to Complete the Client's CSI Admission

1. Once you create the FFS2 admission for the client, click *CSI Admission* in the task bar to open the CSI Admission form.

2. The pre-display for the CSI Admission form will open. Click *Add*.

3. The CSI Admission form will appear. (Red fields indicate that the information is required.)

CSI Admission	
Birth Name (Last)	**Birth Name (First)**
Birth Name (Middle)	**Birth Name (Suffix)** -Please Choose One-
Mother's First Name	**Fiscally Responsible County For Client** -Please Choose One-
Place of Birth - County -Please Choose One-	**Place of Birth - State** -Please Choose One-
Place of Birth - Country -Please Choose One-	**CSI Ethnicity** -Please Choose One-
Special Population -Please Choose One-	**Legal Class** -Please Choose One-
County School -Please Choose One-	**District County Code** -Please Choose One-
District/Site Code -Please Choose One-	**Admission Necessity Code** -Please Choose One-
Is Substance Abuse Affecting Mental Health? -Please Choose One-	**Are Developmental Disabilities Affecting Mental Health?** -Please Choose One-
Are Physical Health Disorders Affecting Mental Health -Please Choose One-	**Conservatorship/CourtStatus** -Please Choose One-
Preferred Language -Please Choose One-	**Race (Select Up to Five)** American Indian or Alaska Native Asian Indian Black or African American Cambodian Chinese Filipino Ctrl+click to choose multiple items (0 currently selected)
Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time.	**Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time.**

[Save CSI Admission]   [Return To Episodes]

4. Enter the corresponding client information in the following fields:
   a. Birth Name (Last)
   b. Birth Name (First)
   c. Birth Name (Middle), if applicable
   d. Mother's First Name

5. Select the appropriate option from the drop down menus for the following fields:
   a. Fiscally Responsible County for Client
   b. Place of Birth – Country
   c. Place of Birth – State
   d. Place of Birth – Country
   e. CSI Ethnicity
   f. Special Population
   g. Legal Class
   h. County School
   i. District County Code
   j. District/Site Code
   k. Admission Necessity Code
   l. Is Substance Abuse Affecting Mental Health?
   m. Are Developmental Disabilities Affecting Mental Health?
   n. Are Physical Health Disorders Affecting Mental Health
   o. Conservatorship/CourtStatus

        p.   Preferred Language

        q.   Race (Select Up to Five)

6.   Enter the corresponding client information in the following fields:
    a. Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time.
    b. Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time.

CSI Admission	
Birth Name (Last) TWO	**Birth Name (First)** ONE
Birth Name (Middle)	**Birth Name (Suffix)** -Please Choose One-
Mother's First Name THREE	**Fiscally Responsible County For Client** Los Angeles
Place of Birth - County Los Angeles	**Place of Birth - State** California
Place of Birth - Country United States	**CSI Ethnicity** Not Hispanic or Latino
Special Population No special population services	**Legal Class** Voluntary
County School Adult and Career Education	**District County Code** Los Angeles
District/Site Code -Please Choose One- *	**Admission Necessity Code** -Please Choose One-
Is Substance Abuse Affecting Mental Health? No	**Are Developmental Disabilities Affecting Mental Health?** No
Are Physical Health Disorders Affecting Mental Health No	**Conservatorship/CourtStatus** Not Applicable
Preferred Language English	**Race (Select Up to Five)** Other Asian Other Pacific Islander Samoan Unknown / Not Reported Vietnamese White or Caucasian Ctrl+click to choose multiple items (1 currently selected)
Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time. 4	**Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time.** 0

Save CSI Admission   Return To Episodes

7.   Click *Save CSI Admission* at the bottom of the form.

ProviderConnect Exercises: Completing Financial Eligibility for the Client

Overview

This exercise will demonstrate the user how to complete the client's financial eligibility, using the Systemwide Annual Liability form and Financial Eligibility form. For the purpose of this exercise, we will assume that the client has other health coverage, such as private insurance, Medicare, and Medi-Cal. The exercises contained in this section will demonstrate the user how to add a private insurance guarantor, the Medicare guarantor, and the Medi-Cal guarantor.

Before completing the forms in this exercise, you must create a financial folder for the client, which entails verifying the client's financial eligibility, and completing the Payer Financial Information form for the client. For more information on how to create the client's financial folder, please refer to the Financial Screening Reference Guide.

Training Exercise: Using the Systemwide Annual Liability Form to Complete Client's Financial Eligibility

1. Once you create the FFS2 admission and complete the CSI Admission form for the client, click *System Annual Liability* in the task bar to open the System Annual Liability form.

2. The pre-display for the System Annual Liability form will open. Click *Add New Record*.

Member ID
3000659

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

Day Treatment / MHS Authorization Details
DCFS Status Tracking
Over Threshold Authorization Request
Public Guardian Status Tracking
Systemwide Annual Liability

Exit to Main Menu

Systemwide Annual Liability Items

	Annual Liability Begin Date	Responsible Legal Entity	Responsible Family Member	Record Creation Date	Annual Liability ($)

Add New Record

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3. The Systemwide Annual Liability form will open. Complete the Systemwide Annual Liability form. (Red fields indicate that the information is required.)

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Print

Systemwide Annual Liability

Annual Liability Begin Date		**Record Creation Date**
Today Yesterday		03/07/2014 Today Yesterday
Responsible Legal Entity		**Record Created By**
▼		Search for: Search
		(%PWRD1USERID%) [existing value] ▼
Monthly Family Income ($)		**Annual Liability ($)**
Responsible Family Member		**Number of Dependents**
Note		

Save Changes   Cancel Changes

4. Enter the client's annual liability begin date in the Annual Liability Begin Date field. The annual liability begin date corresponds to the date that the client was registered to begin the initial annual liability charge period. For brand new clients that have no existing record in ProviderConnect or Avatar, the annual liability begin date should be the same as the client's admission date. For existing clients, the annual liability begin date should be the annual charge from date on section 22 of the client's Payer Financial Information form. For more information on how to determine the client's annual liability begin date, you may refer to the Financial Screening Reference Guide.

5. Select "xFFS2LE Fee For Service 2 Admission" from the Responsible Legal Entity drop down menu. Selecting the wrong option under the Responsible Legal Entity drop down menu will result in adding the client's financial eligibility to the wrong provider. Please be sure to select "xFFS2LE Fee For Service 2 Admission."

6. Enter the client's monthly family income from section 21 of the client's Payer Financial Information form in the Monthly Family Income field.

7. Enter the client's annual liability from section 22 of the client's Payer Financial Information form in the Annual Liability field. For more information on how to determine the client's annual liability amount, you may refer to the Financial Screening Reference Guide.

8. Enter the name of the responsible family member from section 10 of the client's Payer Financial Information form in the Responsible Family Member field, using the following format: LASTNAME,FIRSTNAME.DOB. Do not insert any spaces in this field. For more information on how to determine if the client is the responsible family member, you may refer to the Financial Screening Reference Guide.

9. Enter the number of dependents from section 22 of the Payer Financial Information form in the Number of Dependents field For more information on how to determine the number of dependents for the client, you may refer to the Financial Screening Reference Guide.

10. Enter a note for LACDMH in the Note field, using the following format: provider's first initial, period, provider's last name, provider's phone number, and the message.

11. Click *Save Changes* to submit the form.

Member ID		Client Name:	TWO, ONE
3000659		Member ID:	3000659
		SSN:	987-44-4444

Print

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

Day Treatment / MHS Authorization Details
DCFS Status Tracking
Over Threshold Authorization Request
Public Guardian Status Tracking
Systemwide Annual Liability

Exit to Main Menu

Systemwide Annual Liability

Annual Liability Begin Date			Record Creation Date		
03/07/2014	Today	Yesterday	03/25/2014	Today	Yesterday

Responsible Legal Entity
x FFS2LE Fee For Service 2 Admission ▼

Record Created By
Search for: [ ] Search
(CARELINKUSER) ProviderConnect user (do not edit) ▼

Monthly Family Income ($)	Annual Liability ($)
1200	0

Responsible Family Member	Number of Dependents
TWO,ONE.1/30/1995	4

Note
J.Schmidt 213-555-5555 Client has Medi-Cal--checked on 3/7/2014.

Save Changes   Cancel Changes

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12. The pre-display for the System Annual Liability form will appear, with the client's completed form listed. Click *OK*.

Member ID
3000659

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

Day Treatment / MHS Authorization Details
DCFS Status Tracking
Over Threshold Authorization Request
Public Guardian Status Tracking

Systemwide Annual Liability Items

	Annual Liability Begin Date	Responsible Legal Entity	Responsible Family Member	Record Creation Date	Annual Liability ($)
Select	03/07/2014	x FFS2LE Fee For Service 2 Admission	TWO,ONE.1/30/1995	03/25/2014	0.00

Add New Record

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Message from webpage

⚠ Your changes have been saved.

OK

NOTE: If you need to edit the Systemwide Annual Liability form after submission, click on *Select* to open the existing form and make any corrections necessary.

13. Please move forward to the next training exercise to enter the appropriate guarantors for the client.

Training Exercise: Using the Financial Eligibility Form to Add the Private Insurance Guarantor to Client's Financial Eligibility

1. Click *Financial Eligibility* on the task bar to open the Financial Eligibility form.

2. The Financial Eligibility form will open.

ProviderConnect - Financial Eligibility Information		SCHMIDT, JILL E. 3/7/2014 2:13:38 PM Lookup Client	Main Menu	Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Financial Eligibility

Episode Number	
Admission Date	
Program	
Default Information from Different Episode	Yes - Y No - N
Episode To Default From	
Coverage Comments	

Submit   Cancel

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3. Select the admission from the Episode Number drop down menu.

ProviderConnect - Financial Eligibility Information	SCHMIDT, JILL E. 3/7/2014 2

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Financial Eligibility

Episode Number	
Admission Date	
Program	
Default Information from Different Episode	
Episode To Default From	
Coverage Comments	

Episode Selection   [X]

Episode Number	Admit Date	Discharge Date	Program
1	3/7/2014		x FFS2LE Fee For Service 2 Admission

NOTE: Please be sure to select the "xFFS2LE Fee For Service 2 Admission" if more than one admission is listed in the drop down menu. Selecting any admission other than the FFS2 admission will result in adding the client's financial eligibility to the wrong admission.

4. The Admission Date and Program fields will autopopulate once you select the admission.

5. Select the "No" radio button under the Default Information from Different Episode section. The Guarantor Selection section will appear once No is selected.

6. Select the first guarantor from the drop down menu in the Guarantor section, and click *Add Guarantor*.

NOTE: If the client has private insurance, select the appropriate private insurance guarantor as the first guarantor.

7. The Guarantor Details form will appear. As you can see, the Guarantor Information for the corresponding private insurance autopopulates. Complete the Guarantor Details form via the following steps. (Red fields and red asterisk indicate that the information is required.)

ProviderConnect - Guarantor Details   SCHMIDT, JILL E. 4/4/2014 11:59:23 AM   Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Guarantor Information

| Guarantor Order | Guarantor Name |
| 1 | Blue Shield of California Blue Card IPS |

| Guarantor's Address - Line 1 | Guarantor's Address - Line 2 |
| PO Box 1505 | |

| Guarantor's Address - City | Guarantor's Address - Zipcode |
| Red Bluff | 96080 |

| Guarantor's Address - State | Guarantor's Phone Number |
| CA - CALIFORNIA | 800-676-2583 |

| Guarantor Plan | Customize Guarantor Plan |
| PRIVATE INSURANCE | ● Yes - Y ● No - N * |

Billing Plan Assigned

Level Start Date	Level End Date	Deductible Type	Deductible Amount	Per Diem Rate	
01/01/2000					

You must add this Guarantor record prior to editing any defaulted billing plan information.

Subscriber Information

| Subscriber's Name | Client's Relationship To Subscriber |
| | -Please Choose One- * |

| Subscriber Address - Street Line 1 | Subscriber Address - Street Line 2 |
| | |

| Subscriber Address - City | Subscriber Address - State |
| | -Please Choose One- * |

Subscriber Address - Zip	**Subscriber Address - County**
[ ]	-Please Choose One- ▼
Subscriber Phone Number	**Subscriber's Social Security #**
[ ]	[ ]
Subscriber Sex	**Subscribers Employment Status**
-Please Choose One- ▼ *	-Please Choose One- ▼
Subscriber's Birth Date	**Subscriber Employee ID #**
[ ]	[ ]
Subscriber Employer Name	**Subscriber Employer ID Number**
[ ]	[ ]
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
[ ]	[ ]
Subscriber Employer Add - Zip	**Subscriber Employer Add - County**
[ ]	-Please Choose One- ▼
Subscriber Employer Add - State	**Subscriber Work Phone**
-Please Choose One- ▼	[ ]
Subscriber Group Name	**Subscriber Group Number**
[ ]	[ ]
Subscriber Policy Number	**Subscriber Medicare Number**
[ ]	[ ]
Subscriber Medicaid #	**Subscriber MEDS ID #**
[ ]	[ ]
Subscriber Client Index #	**Subscriber Branch of Service**
[ ]	-Please Choose One- ▼
Subscriber Military Status	**Subscriber Treatment Auth**
-Please Choose One- ▼	○ Yes - Y ○ No - N
Subscriber Assignment Of Benefits	**Subscriber Release Of Information**
⦿ Yes - Y ⦿ No - N *	⦿ Appropriate Release Of Information On File At HCSP - A ⦿ Informed Consent To Release Medical Info - I ⦿ No, Provider Not Allowed To Release Data - N ⦿ On File At Payor Or At Plan Sponsor - O ⦿ Provider Has Limited/Restricted Ability To Release Data - M ⦿ Yes, Provider Has Signed Statement Permitting Release - Y *

Coverage Information

Eligibility Verified	**Coverage Effective Date**
⦿ Yes - Y ⦿ No - N *	[ ]
Coverage Expiration Date	**Inhibit Billing By Mail**
[ ]	○ Yes - Y ○ No - N
Effective Date Of Contract	**Expiration Date Of Contract**
01/01/2000	[ ]
Is This A Managed Care Contract	**Insurance Code/Medicaid Tape**
○ Yes - Y ○ No - N	[ ]
Coordination Of Benefits	**Date Of Accident**
⦿ Yes - Y ⦿ No - N *	[ ]
Date Benefits Terminated	**Date Benefits Denied**
[ ]	[ ]
Denial Code	**Subscriber's Covered Days**
-Please Choose One- ▼	9999
Number Of Days For Interim Billing	**Maximum Covered Dollars**
[ ]	99999999.99
Lifetime Reserve Days	
[ ]	

Notes

[   ]

Save   Cancel

8. Select the "No" radio button under Customize Guarantor Plan in the Guarantor Information section.

Guarantor Information

Guarantor Order	Guarantor Name
1	Blue Shield of California Blue Card IPS
Guarantor's Address - Line 1	**Guarantor's Address - Line 2**
PO Box 1505	
Guarantor's Address - City	**Guarantor's Address - Zipcode**
Red Bluff	96080
Guarantor's Address - State	**Guarantor's Phone Number**
CA - CALIFORNIA	800-676-2583
Guarantor Plan	**Customize Guarantor Plan**
PRIVATE INSURANCE	○ Yes - Y ● No - N

9. Complete the Subscriber Information section via the following steps:
    a. Enter the client's name, address, social security number, and sex.
    b. Select the client's relationship to the subscriber. If the policy is under the client's name, select "Self" from the Client's Relationship to Subscriber drop down menu, and the system will autopopulate the client's name, address, social security number, and sex, and you can avoid entering the information in those fields manually.
    c. Select the "Yes" radio button under Subscriber Assignment of Benefits.
    d. Select the "Yes, Provider Has Signed Statement Permitting Release - Y" radio button under Subscriber Release of Information. Please note that if the client has private insurance, the provider is required to retain a signed copy of the Insurance Authorization and Assignment of Benefits form in the client's financial folder, as described in the Financial Screening Reference Guide.

Subscriber Information

Subscriber's Name	Client's Relationship To Subscriber
TWO,ONE	Self - 1
Subscriber Address - Street Line 1	**Subscriber Address - Street Line 2**
1000 1ST STREET	APT 8
Subscriber Address - City	**Subscriber Address - State**
LOS ANGELES	CA - CALIFORNIA
Subscriber Address - Zip	**Subscriber Address - County**
90012	-Please Choose One-
Subscriber Phone Number	**Subscriber's Social Security #**
	987-44-4444
Subscriber Sex	**Subscribers Employment Status**
Male - M	
Subscriber's Birth Date	**Subscriber Employee ID #**
01/30/1995	
Subscriber Employer Name	**Subscriber Employer ID Number**
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
Subscriber Employer Add - Zip	**Subscriber Employer Add - County**
	-Please Choose One-
Subscriber Employer Add - State	**Subscriber Work Phone**
-Please Choose One-	
Subscriber Group Name	**Subscriber Group Number**
Subscriber Policy Number	**Subscriber Medicare Number**
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index #	**Subscriber Branch of Service**
	-Please Choose One-
Subscriber Military Status	**Subscriber Treatment Auth**
-Please Choose One-	● Yes - Y ○ No - N
Subscriber Assignment Of Benefits	**Subscriber Release Of Information**
● Yes - Y ○ No - N	○ Appropriate Release Of Information On File At HCSP - A ○ Informed Consent To Release Medical Info - I ○ No, Provider Not Allowed To Release Data - N ○ On File At Payor Or At Plan Sponsor - O ○ Provider Has Limited/Restricted Ability To Release Data - M ● Yes, Provider Has Signed Statement Permitting Release - Y

10. Complete the Coverage Information section via the following steps:

a. Select the "Yes" radio button under Eligibility Verified.
b. Enter the client's Coverage Effective Date. The coverage effective date is the date that client's insurance policy became effective.
c. Select the "Yes" radio button under Coordination of Benefits.

Coverage Information	
Eligibility Verified ● Yes - Y ○ No - N	**Coverage Effective Date** 01/01/2014
Coverage Expiration Date	**Inhibit Billing By Mail** ○ Yes - Y ○ No - N
Effective Date Of Contract 01/01/2000	**Expiration Date Of Contract**
Is This A Managed Care Contract ○ Yes - Y ○ No - N	**Insurance Code/Medicaid Tape**
Coordination Of Benefits ● Yes - Y ○ No - N	**Date Of Accident**
Date Benefits Terminated	**Date Benefits Denied**
Denial Code -Please Choose One-	**Subscriber's Covered Days** 9999
Number Of Days For Interim Billing	**Maximum Covered Dollars** 99999999.99
Lifetime Reserve Days	
Notes	

Save   Cancel

NOTE: The Effective Date of Contract, Subscriber Covered Days, and Maximum Covered Dollars autopopulate in the form. Please do not modify the information in these three fields.

11. Click *Save* to submit the form.

12. The Financial Eligibility Information form will appear. Under the Guarantor Selection section, you will see the client's private insurance listed as a guarantor.

Financial Eligibility	
Episode Number	1
Admission Date	3/7/2014
Program	x FFS2LE Fee For Service 2 Admission
Default Information from Different Episode	○ Yes - Y ● No - N
Episode To Default From	
Coverage Comments	

Guarantor Selection			
Change Order	**Guarantor Name**		
↓ ↑	Blue Shield of California Blue Card IPS	Edit	Delete
-- Guarantors --	Add Guarantor		

Submit   Cancel

13. Please continue to the next training exercise to enter the Medicare guarantor.

Training Exercise: Using the Financial Eligibility Form to Add the Medicare Guarantor to Client's Financial Eligibility

1. Select the Medicare guarantor from the drop down menu in the Guarantor section, and click *Add Guarantor*.

Guarantor Selection				
Change Order	**Guarantor Name**			
↓ ↑	Blue Shield of California Blue Card IPS		Edit	Delete
Medicare (12) ▼	Add Guarantor			

Submit   Cancel

2. The Guarantor Details form will appear. As you can see, the Guarantor Information for the Medicare guarantor autopopulates. Complete the Guarantor Details form via the following steps. (Red fields and red asterisk indicate that the information is required.)

ProviderConnect - Guarantor Details	SCHMIDT, JILL E. 4/4/2014 12:49:38 PM Lookup Client	Main Menu	Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Guarantor Information	
Guarantor Order 2	**Guarantor Name** Noridian
Guarantor's Address - Line 1 PO Box 6775	**Guarantor's Address - Line 2**
Guarantor's Address - City Fargo	**Guarantor's Address - Zipcode** 58108-6775
Guarantor's Address - State ND - NORTH DAKOTA ▼	**Guarantor's Phone Number** 855-609-9960
Guarantor Plan MEDICARE ▼	**Customize Guarantor Plan** ⊙ Yes - Y ⊙ No - N *

Billing Plan Assigned					
Level Start Date	Level End Date	Deductible Type	Deductible Amount	Per Diem Rate	
01/01/2000					
You must add this Guarantor record prior to editing any defaulted billing plan information.					

Subscriber Information	
Subscriber's Name [ ]	**Client's Relationship To Subscriber** -Please Choose One- ▼ *
Subscriber Address - Street Line 1 [ ]	**Subscriber Address - Street Line 2** [ ]
Subscriber Address - City [ ]	**Subscriber Address - State** -Please Choose One- ▼ *

Subscriber Address - Zip	**Subscriber Address - County** -Please Choose One- ▾
Subscriber Phone Number	**Subscriber's Social Security #**
Subscriber Sex -Please Choose One- ▾ *	**Subscribers Employment Status** -Please Choose One- ▾
Subscriber's Birth Date	**Subscriber Employee ID #**
Subscriber Employer Name	**Subscriber Employer ID Number**
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
Subscriber Employer Add - Zip	**Subscriber Employer Add - County** -Please Choose One- ▾
Subscriber Employer Add - State -Please Choose One- ▾	**Subscriber Work Phone**
Subscriber Group Name	**Subscriber Group Number**
Subscriber Policy Number	**Subscriber Medicare Number**
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index #	**Subscriber Branch of Service** -Please Choose One- ▾
Subscriber Military Status -Please Choose One- ▾	**Subscriber Treatment Auth** ○ Yes - Y ○ No - N
Subscriber Assignment Of Benefits ◉ Yes - Y ◉ No - N *	**Subscriber Release Of Information** ◉ Appropriate Release Of Information On File At HCSP - A ◉ Informed Consent To Release Medical Info - I ◉ No, Provider Not Allowed To Release Data - N ◉ On File At Payor Or At Plan Sponsor - O ◉ Provider Has Limited/Restricted Ability To Release Data - M ◉ Yes, Provider Has Signed Statement Permitting Release - Y *

Coverage Information

Eligibility Verified ◉ Yes - Y ◉ No - N *	**Coverage Effective Date**
Coverage Expiration Date	**Inhibit Billing By Mail** ○ Yes - Y ○ No - N
Effective Date Of Contract 09/16/2013	**Expiration Date Of Contract**
Is This A Managed Care Contract ○ Yes - Y ◉ No - N	**Insurance Code/Medicaid Tape**
Coordination Of Benefits ◉ Yes - Y ◉ No - N *	**Date Of Accident**
Date Benefits Terminated	**Date Benefits Denied**
Denial Code -Please Choose One- ▾	**Subscriber's Covered Days** 9999
Number Of Days For Interim Billing	**Maximum Covered Dollars** 99999999.99
Lifetime Reserve Days	

Notes

Save   Cancel

3. Select the "No" radio button under Customize Guarantor Plan in the Guarantor Information section.

Guarantor Information	
Guarantor Order 2	**Guarantor Name** Noridian
Guarantor's Address - Line 1 PO Box 6775	**Guarantor's Address - Line 2**
Guarantor's Address - City Fargo	**Guarantor's Address - Zipcode** 58108-6775
Guarantor's Address - State ND - NORTH DAKOTA	**Guarantor's Phone Number** 855-609-9960
Guarantor Plan MEDICARE	**Customize Guarantor Plan** ○ Yes - Y ● No - N

4. Complete the Subscriber Information section via the following steps:
   a. Enter the client's name, address, social security number, and sex.
   b. Select the client's relationship to the subscriber. If the policy is under the client's name, select "Self" from the Client's Relationship to Subscriber drop down menu, and the system will autopopulate the client's name, address, social security number, and sex, and you can avoid entering the information in those fields manually.
   c. Enter the HIC number, otherwise known as the Medicare number, from the client's Medicare card in the Subscriber Policy Number field and the Subscriber Medicare Number field. The client's HIC number can also be attained by calling Noridian in the event that the client cannot provide proof of Medicare.
   d. Select the "Yes" radio button under Subscriber Assignment of Benefits.
   e. Select the "Yes, Provider Has Signed Statement Permitting Release - Y" radio button under Subscriber Release of Information. Please note that if the client has Medicare, the provider is required to keep a signed copy of the Lifetime Extended Signature Authorization form in the client's financial folder, as described in the Financial Screening Reference Guide.

Subscriber Information

Subscriber's Name	Client's Relationship To Subscriber
TWO,ONE	Self - 1
Subscriber Address - Street Line 1	**Subscriber Address - Street Line 2**
1000 1ST STREET	APT 8
Subscriber Address - City	**Subscriber Address - State**
LOS ANGELES	CA - CALIFORNIA
Subscriber Address - Zip	**Subscriber Address - County**
90012	-Please Choose One-
Subscriber Phone Number	**Subscriber's Social Security #**
	987-44-4444
Subscriber Sex	**Subscribers Employment Status**
Male - M	
Subscriber's Birth Date	**Subscriber Employee ID #**
01/30/1995	
Subscriber Employer Name	**Subscriber Employer ID Number**
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
Subscriber Employer Add - Zip	**Subscriber Employer Add - County**
	-Please Choose One-
Subscriber Employer Add - State	**Subscriber Work Phone**
-Please Choose One-	
Subscriber Group Name	**Subscriber Group Number**
Subscriber Policy Number	**Subscriber Medicare Number**
987444444A	987444444A
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index #	**Subscriber Branch of Service**
	-Please Choose One-
Subscriber Military Status	**Subscriber Treatment Auth**
-Please Choose One-	● Yes - Y ○ No - N
Subscriber Assignment Of Benefits	**Subscriber Release Of Information**
● Yes - Y ○ No - N	○ Appropriate Release Of Information On File At HCSP - A ○ Informed Consent To Release Medical Info - I ○ No, Provider Not Allowed To Release Data - N ○ On File At Payor Or At Plan Sponsor - O ○ Provider Has Limited/Restricted Ability To Release Data - M ● Yes, Provider Has Signed Statement Permitting Release - Y

5. Complete the Coverage Information section via the following steps:
    a. Select the "Yes" radio button under Eligibility Verified.
    b. Enter the client's Coverage Effective Date. The coverage effective date is the effective date on the client's Medicare card. The client's Medicare effective date can also be derived by calling Noridian.
    c. Select the "Yes" radio button under Coordination of Benefits.

Coverage Information	
Eligibility Verified ● Yes - Y ○ No - N	**Coverage Effective Date** 01/01/2014
Coverage Expiration Date 	**Inhibit Billing By Mail** ○ Yes - Y ○ No - N
Effective Date Of Contract 09/16/2013	**Expiration Date Of Contract**
Is This A Managed Care Contract ○ Yes - Y ● No - N	**Insurance Code/Medicaid Tape**
Coordination Of Benefits ● Yes - Y ○ No - N	**Date Of Accident**
Date Benefits Terminated 	**Date Benefits Denied**
Denial Code -Please Choose One-	**Subscriber's Covered Days** 9999
Number Of Days For Interim Billing 	**Maximum Covered Dollars** 99999999.99
Lifetime Reserve Days 	
Notes 	

Save   Cancel

NOTE: The Effective Date of Contract, Subscriber Covered Days, and Maximum Covered Dollars autopopulate in the form. Please do not modify the information in these three fields.

6. Click *Save* to submit the form.

7. The Financial Eligibility Information form will appear. Under the Guarantor Selection section, you will see Noridian listed as a guarantor.

Financial Eligibility	
Episode Number	1
Admission Date	3/7/2014
Program	x FFS2LE Fee For Service 2 Admission
Default Information from Different Episode	○ Yes - Y ○ No - N
Episode To Default From	
Coverage Comments	

Guarantor Selection				
Change Order	**Guarantor Name**			
↓ ↑	Blue Shield of California Blue Card IPS		Edit	Delete
↓ ↑	Noridian		Edit	Delete

-- Guarantors --   ▼   Add Guarantor

Submit   Cancel

NOTE: Please note that the Medicare guarantor will be listed as "Noridian" in the Guarantor Selection section of the Financial Eligibility form.

8. Please continue to the next training exercise to enter the Medi-Cal guarantor.

Training Exercise: Using the Financial Eligibility Form to Add the Medi-Cal Guarantor to Client's Financial Eligibility

1. Select the Medi-Cal guarantor in the Guarantor section, and click *Add Guarantor*.

Guarantor Selection			
Change Order	**Guarantor Name**		
↓ ↑	Blue Shield of California Blue Card IPS	Edit	Delete
↓ ↑	Noridian	Edit	Delete
Medi-Cal (10) ▾ Add Guarantor			

Submit   Cancel

2. The Guarantor Details form will appear. As you can see, the Guarantor Information for Medi-Cal autopopulates. Complete the Guarantor Details form via the following steps. (Red fields and red asterisk indicate that the information is required.)

Guarantor Information	
Guarantor Order 3	**Guarantor Name** DMH
Guarantor's Address - Line 1 1901 16TH STREET	**Guarantor's Address - Line 2**
Guarantor's Address - City Sacramento	**Guarantor's Address - Zipcode** 95814
Guarantor's Address - State CA - CALIFORNIA ▾	**Guarantor's Phone Number**
Guarantor Plan MEDI-CAL ▾	**Customize Guarantor Plan** ⦿ Yes - Y ⦿ No - N *

Billing Plan Assigned				
Level Start Date	Level End Date	Deductible Type	Deductible Amount	Per Diem Rate
01/01/2000				

You must add this Guarantor record prior to editing any defaulted billing plan information.

Subscriber Information	
Subscriber's Name	**Client's Relationship To Subscriber** -Please Choose One- ▾ *
Subscriber Address - Street Line 1	**Subscriber Address - Street Line 2**
Subscriber Address - City	**Subscriber Address - State** -Please Choose One- ▾ *

Subscriber Address - Zip	**Subscriber Address - County**
	-Please Choose One-
Subscriber Phone Number	**Subscriber's Social Security #**
Subscriber Sex	**Subscribers Employment Status**
-Please Choose One- *	-Please Choose One-
Subscriber's Birth Date	**Subscriber Employee ID #**
Subscriber Employer Name	**Subscriber Employer ID Number**
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
Subscriber Employer Add - Zip	**Subscriber Employer Add - County**
	-Please Choose One-
Subscriber Employer Add - State	**Subscriber Work Phone**
-Please Choose One-	
Subscriber Group Name	**Subscriber Group Number**
Subscriber Policy Number	**Subscriber Medicare Number**
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index #	**Subscriber Branch of Service**
	-Please Choose One-
Subscriber Military Status	**Subscriber Treatment Auth**
-Please Choose One-	○ Yes - Y ○ No - N
Subscriber Assignment Of Benefits ◉ Yes - Y ◉ No - N *	**Subscriber Release Of Information** ◉ Appropriate Release Of Information On File At HCSP - A ◉ Informed Consent To Release Medical Info - I ◉ No, Provider Not Allowed To Release Data - N ◉ On File At Payor Or At Plan Sponsor - O ◉ Provider Has Limited/Restricted Ability To Release Data - M ◉ Yes, Provider Has Signed Statement Permitting Release - Y *

Coverage Information	
Eligibility Verified ◉ Yes - Y ◉ No - N *	**Coverage Effective Date**
Coverage Expiration Date	**Inhibit Billing By Mail** ○ Yes - Y ○ No - N
Effective Date Of Contract 01/01/2000	**Expiration Date Of Contract**
Is This A Managed Care Contract ○ Yes - Y ○ No - N	**Insurance Code/Medicaid Tape**
Coordination Of Benefits ◉ Yes - Y ◉ No - N *	**Date Of Accident**
Date Benefits Terminated	**Date Benefits Denied**
Denial Code -Please Choose One-	**Subscriber's Covered Days** 9999
Number Of Days For Interim Billing	**Maximum Covered Dollars** 99999999.99
Lifetime Reserve Days	
Effective Date of Medi-Cal Eligibility	**Eligibility Code** -Please Choose One-
Aid Code -Please Choose One-	**EVC Tracking #**
Notes	

[Save] [Cancel]

3. Select the "No" radio button under Customize Guarantor Plan in the Guarantor Information section.

Guarantor Information	
Guarantor Order 3	**Guarantor Name** DMH
Guarantor's Address - Line 1 1901 16TH STREET	**Guarantor's Address - Line 2**
Guarantor's Address - City Sacramento	**Guarantor's Address - Zipcode** 95814
Guarantor's Address - State CA - CALIFORNIA	**Guarantor's Phone Number**
Guarantor Plan MEDI-CAL	**Customize Guarantor Plan** ○ Yes - Y ⦿ No - N

4. Complete the Subscriber Information section via the following steps:
   a. Select the client's relationship to the subscriber. If the policy is under the client's name, select "Self" from the Client's Relationship to Subscriber drop down menu, and the system will autopopulate the client's name, address, social security number, and sex, and you can avoid entering the information in those fields manually. If the policy is not under the client's name, select the appropriate option in the Client's Relationship to Subscriber drop down menu, and enter the client's name, address, social security number, and sex information manually.
   b. Enter the CIN number, otherwise known as the Medi-Cal number, from the client's Medi-Cal card in the Subscriber Policy Number field and the Subscriber Client Index # field. The CIN number can also be found on the eligibility response attained from the state's Medi-Cal website that is used to verify the client's Medi-Cal eligibility in the event that the client cannot provide proof of Medi-Cal.
   c. Select the "Yes" radio button under Subscriber Assignment of Benefits.
   d. Select the "Informed Consent to Release Medical Info - I" radio button under Subscriber Release of Information. Please note that if the client has Medi-Cal, the provider is required to attain consent from the client that to release his/her medical information.

Subscriber Information

Subscriber's Name TWO,ONE	**Client's Relationship To Subscriber** Self - 1
Subscriber Address - Street Line 1 1000 1ST STREET	**Subscriber Address - Street Line 2** APT 8
Subscriber Address - City LOS ANGELES	**Subscriber Address - State** CA - CALIFORNIA
Subscriber Address - Zip 90012	**Subscriber Address - County** Los Angeles - 19
Subscriber Phone Number	**Subscriber's Social Security #** 987-44-4444
Subscriber Sex Male - M	**Subscribers Employment Status** -Please Choose One-
Subscriber's Birth Date	**Subscriber Employee ID #**
Subscriber Employer Name	**Subscriber Employer ID Number**
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
Subscriber Employer Add - Zip	**Subscriber Employer Add - County** -Please Choose One-
Subscriber Employer Add - State -Please Choose One-	**Subscriber Work Phone**
Subscriber Group Name	**Subscriber Group Number**
Subscriber Policy Number 99999999A	**Subscriber Medicare Number**
Subscriber Medicaid #	**Subscriber MEDS ID #** 987444444
Subscriber Client Index # 99999999A	**Subscriber Branch of Service** -Please Choose One-
Subscriber Military Status -Please Choose One-	**Subscriber Treatment Auth** ● Yes - Y ○ No - N
Subscriber Assignment Of Benefits ● Yes - Y ○ No - N	**Subscriber Release Of Information** ○ Appropriate Release Of Information On File At HCSP - A ● Informed Consent To Release Medical Info - I ○ No, Provider Not Allowed To Release Data - N ○ On File At Payor Or At Plan Sponsor - O ○ Provider Has Limited/Restricted Ability To Release Data - M ○ Yes, Provider Has Signed Statement Permitting Release - Y

5. Complete the Coverage Information section via the following steps:
    a. Select the "Yes" radio button under Eligibility Verified.
    b. Enter the client's Coverage Effective Date. The coverage effective date is the BIC issue date from the client's Medi-Cal card. The BIC issue date can also be derived by using the Julian calendar method after attaining the client's CIN number listed on the eligibility response via the Medi-Cal website, as further explained in the Financial Screening Reference Guide.
    c. Select the "Yes" radio button under Coordination of Benefits.
    d. Delete the prepopulated information in the Effective Date of Medi-Cal Eligibility field.
    e. Select "Please Choose One" option from the Aid Code drop down menu.
    f. Select "Please Choose One" option from the Eligibility Code drop down menu.
    g. Enter the EVC Tracking # from the client's Medi-Cal eligibility response that is provided via the state's Medi-Cal website.

Coverage Information	
Eligibility Verified ⦿ Yes - Y ○ No - N	**Coverage Effective Date** 01/01/2014
Coverage Expiration Date	**Inhibit Billing By Mail** ○ Yes - Y ○ No - N
Effective Date Of Contract 01/01/2000	**Expiration Date Of Contract**
Is This A Managed Care Contract ○ Yes - Y ○ No - N	**Insurance Code/Medicaid Tape**
Coordination Of Benefits ⦿ Yes - Y ○ No - N	**Date Of Accident**
Date Benefits Terminated	**Date Benefits Denied**
Denial Code -Please Choose One-	**Subscriber's Covered Days** 9999
Number Of Days For Interim Billing	**Maximum Covered Dollars** 99999999.99
Lifetime Reserve Days	
Effective Date of Medi-Cal Eligibility	**Eligibility Code** -Please Choose One-
Aid Code -Please Choose One-	**EVC Tracking #**
Notes	

Save   Cancel

NOTE: The Effective Date of Contract, Subscriber Covered Days, and Maximum Covered Dollars autopopulate in the form. Please do not modify the information in these three fields.

6. Click *Save* to submit the form.

7. The Financial Eligibility Information form will appear. Under the Guarantor Selection section, you will see DMH listed as a guarantor.

Financial Eligibility	
Episode Number	1
Admission Date	3/7/2014
Program	x FFS2LE Fee For Service 2 Admission
Default Information from Different Episode	○ Yes - Y ● No - N
Episode To Default From	
Coverage Comments	

Guarantor Selection			
Change Order	Guarantor Name		
↓ ↑	Blue Shield of California Blue Card IPS	Edit	Delete
↓ ↑	Noridian	Edit	Delete
↓ ↑	DMH	Edit	Delete
-- Guarantors --	Add Guarantor		

Submit   Cancel

NOTE: Please note that the Medi-Cal guarantor will be listed as "DMH" in the Guarantor Selection section of the Financial Eligibility form. This merely is a reference to the former State of California Department of Mental Health, and it should not be mistaken for the Los Angeles County Department of Mental Health.

Training Exercise: Using the Financial Eligibility Form to Add the Los Angeles County Department of Mental Health Guarantor to Client's Financial Eligibility

1. Select LA County from the Guarantor drop down menu in the Guarantor Selection section, and click *Add Guarantor*.

Guarantor Selection			
Change Order	**Guarantor Name**		
↓ ↑	Blue Shield of California Blue Card IPS	Edit	Delete
↓ ↑	Noridian	Edit	Delete
↓ ↑	DMH	Edit	Delete
LA County (16) ▾	Add Guarantor		

Submit   Cancel

2. The Guarantor Details form will appear. As you can see, the Guarantor Information for the LA County guarantor autopopulates. Complete the Guarantor Details form via the following steps. (Red fields and red asterisk indicate that the information is required.)

ProviderConnect - Guarantor Details   SCHMIDT, JILL E.   4/4/2014 1:32:42 PM   Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Guarantor Information	
Guarantor Order 4	**Guarantor Name** LA County
Guarantor's Address - Line 1 550 S Vermont Ave	**Guarantor's Address - Line 2**
Guarantor's Address - City Los Angeles	**Guarantor's Address - Zipcode** 90020-1912
Guarantor's Address - State CA - CALIFORNIA ▾	**Guarantor's Phone Number**
Guarantor Plan LA COUNTY ▾	**Customize Guarantor Plan** ● Yes - Y ● No - N *

Billing Plan Assigned				
Level Start Date	Level End Date	Deductible Type	Deductible Amount	Per Diem Rate
01/01/2000				

You must add this Guarantor record prior to editing any defaulted billing plan information.

Subscriber Information	
Subscriber's Name	**Client's Relationship To Subscriber** -Please Choose One- ▾ *
Subscriber Address - Street Line 1	**Subscriber Address - Street Line 2**
Subscriber Address - City	**Subscriber Address - State** -Please Choose One- ▾ *

Subscriber Address - Zip	**Subscriber Address - County**
[ ]	-Please Choose One- ▼
Subscriber Phone Number	**Subscriber's Social Security #**
[ ]	[ ]
Subscriber Sex	**Subscribers Employment Status**
-Please Choose One- ▼ *	-Please Choose One- ▼
Subscriber's Birth Date	**Subscriber Employee ID #**
[ ]	[ ]
Subscriber Employer Name	**Subscriber Employer ID Number**
[ ]	[ ]
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
[ ]	[ ]
Subscriber Employer Add - Zip	**Subscriber Employer Add - County**
[ ]	-Please Choose One- ▼
Subscriber Employer Add - State	**Subscriber Work Phone**
-Please Choose One- ▼	[ ]
Subscriber Group Name	**Subscriber Group Number**
[ ]	[ ]
Subscriber Policy Number	**Subscriber Medicare Number**
[ ]	[ ]
Subscriber Medicaid #	**Subscriber MEDS ID #**
[ ]	[ ]
Subscriber Client Index #	**Subscriber Branch of Service**
[ ]	-Please Choose One- ▼
Subscriber Military Status	**Subscriber Treatment Auth**
-Please Choose One- ▼	○ Yes - Y ○ No - N
Subscriber Assignment Of Benefits	**Subscriber Release Of Information**
◉ Yes - Y ◉ No - N *	◉ Appropriate Release Of Information On File At HCSP - A ◉ Informed Consent To Release Medical Info - I ◉ No, Provider Not Allowed To Release Data - N ◉ On File At Payor Or At Plan Sponsor - O ◉ Provider Has Limited/Restricted Ability To Release Data - M ◉ Yes, Provider Has Signed Statement Permitting Release - Y *

Coverage Information	
Eligibility Verified	**Coverage Effective Date**
◉ Yes - Y ◉ No - N *	[ ]
Coverage Expiration Date	**Inhibit Billing By Mail**
[ ]	○ Yes - Y ○ No - N
Effective Date Of Contract	**Expiration Date Of Contract**
01/01/2000	[ ]
Is This A Managed Care Contract	**Insurance Code/Medicaid Tape**
○ Yes - Y ○ No - N	[ ]
Coordination Of Benefits	**Date Of Accident**
◉ Yes - Y ◉ No - N *	[ ]
Date Benefits Terminated	**Date Benefits Denied**
[ ]	[ ]
Denial Code	**Subscriber's Covered Days**
-Please Choose One- ▼	9999
Number Of Days For Interim Billing	**Maximum Covered Dollars**
[ ]	99999999.99
Lifetime Reserve Days	
[ ]	
Effective Date of Medi-Cal Eligibility	**Eligibility Code**
[ ]	-Please Choose One- ▼
Aid Code	**EVC Tracking #**
-Please Choose One- ▼	[ ]
Notes	
[ ]	

Save   Cancel

3. Select the "No" radio button under Customize Guarantor Plan in the Guarantor Information section.

Guarantor Information	
Guarantor Order 4	**Guarantor Name** LA County
Guarantor's Address - Line 1 550 S Vermont Ave	**Guarantor's Address - Line 2**
Guarantor's Address - City Los Angeles	**Guarantor's Address - Zipcode** 90020-1912
Guarantor's Address - State CA - CALIFORNIA	**Guarantor's Phone Number**
Guarantor Plan LA COUNTY	**Customize Guarantor Plan** ○ Yes - Y ● No - N

4. Complete the Subscriber Information section via the following steps:
   a. Enter the client's name, address, social security number, and sex.
   b. Select the client's relationship to the subscriber. If the policy is under the client's name, select "Self" from the Client's Relationship to Subscriber drop down menu, and the system will autopopulate the client's name, address, social security number, and sex, and you can avoid entering the information in those fields manually.
   c. Select the "Yes" radio button under Subscriber Assignment of Benefits.
   d. Select the "Yes, Provider Has Signed Statement Permitting Release - Y" radio button under Subscriber Release of Information.

Subscriber Information	
Subscriber's Name TWO,ONE	**Client's Relationship To Subscriber** Self - 1
Subscriber Address - Street Line 1 1000 1ST STREET	**Subscriber Address - Street Line 2** APT 8
Subscriber Address - City LOS ANGELES	**Subscriber Address - State** CA - CALIFORNIA
Subscriber Address - Zip 90012	**Subscriber Address - County** -Please Choose One-
Subscriber Phone Number	**Subscriber's Social Security #** 987-44-4444
Subscriber Sex Male - M	**Subscribers Employment Status**
Subscriber's Birth Date 01/30/1995	**Subscriber Employee ID #**
Subscriber Employer Name	**Subscriber Employer ID Number**
Subscriber Employer Add - Street	**Subscriber Employer Add - City**
Subscriber Employer Add - Zip	**Subscriber Employer Add - County** -Please Choose One-
Subscriber Employer Add - State -Please Choose One-	**Subscriber Work Phone**
Subscriber Group Name	**Subscriber Group Number**
Subscriber Policy Number 987444444	**Subscriber Medicare Number**
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index #	**Subscriber Branch of Service** -Please Choose One-
Subscriber Military Status -Please Choose One-	**Subscriber Treatment Auth** ○ Yes - Y ○ No - N
Subscriber Assignment Of Benefits ● Yes - Y ○ No - N	**Subscriber Release Of Information** ○ Appropriate Release Of Information On File At HCSP - A ○ Informed Consent To Release Medical Info - I ○ No, Provider Not Allowed To Release Data - N ○ On File At Payor Or At Plan Sponsor - O ○ Provider Has Limited/Restricted Ability To Release Data - M ● Yes, Provider Has Signed Statement Permitting Release - Y

5. Complete the Coverage Information section via the following steps:
   a. Select the "Yes" radio button under Eligibility Verified.
   b. Enter the client's Coverage Effective Date. The coverage effective date is the Annual Liability Begin Date, which corresponds to the date that the client was registered to begin the initial annual liability charge period. For brand new clients that have no existing record in ProviderConnect or Avatar, the annual liability begin date should be the same as the client's admission date. For existing clients, the annual liability begin date should be the annual charge from date on section 22 of the client's Payer Financial Information form. Make sure that the date that is entered in the Coverage Effective Date field is the same as the date entered in the Annual Liability Begin Date field of the Systemwide Annual Liability form. For more information on how to determine the client's annual liability begin date, you may refer to the Financial Screening Reference Guide.
   c. Select the "Yes" radio button under Coordination of Benefits.

Coverage Information

Eligibility Verified	Coverage Effective Date
◉ Yes - Y ○ No - N	03/07/2014
Coverage Expiration Date	**Inhibit Billing By Mail**
	○ Yes - Y ○ No - N
Effective Date Of Contract	**Expiration Date Of Contract**
01/01/2000	
Is This A Managed Care Contract	**Insurance Code/Medicaid Tape**
○ Yes - Y ○ No - N	
Coordination Of Benefits	**Date Of Accident**
◉ Yes - Y ○ No - N	
Date Benefits Terminated	**Date Benefits Denied**
Denial Code	**Subscriber's Covered Days**
-Please Choose One- ▼	9999
Number Of Days For Interim Billing	**Maximum Covered Dollars**
	99999999.99
Lifetime Reserve Days	
Notes	

Save   Cancel

NOTE: The Effective Date of Contract, Subscriber Covered Days, and Maximum Covered Dollars autopopulate in the form. Please do not modify the information in these three fields.

6. Click *Save* to submit the form.

7. The Financial Eligibility Information form will appear. Under the Guarantor Selection section, you will see LA County listed as a guarantor.

Financial Eligibility	
Episode Number	1
Admission Date	3/7/2014
Program	x FFS2LE Fee For Service 2 Admission
Default Information from Different Episode	☐ Yes - Y ☑ No - N
Episode To Default From	[▾]
Coverage Comments	[ ]

Guarantor Selection				
Change Order	Guarantor Name			
↓ ↑	Blue Shield of California Blue Card IPS		Edit	Delete
↓ ↑	Noridian		Edit	Delete
↓ ↑	DMH		Edit	Delete
↓ ↑	LA County		Edit	Delete
-- Guarantors -- [▾] Add Guarantor				

Submit   Cancel

8. Your Financial Eligibility Information form should look like the following screenshot when it is completed. The client's private insurance should be listed as the first guarantor (if applicable), Noridian should be listed as the second guarantor, DMH should be listed as the third guarantor, and LA County should be listed as the fourth guarantor. If they are not in the appropriate order, you may use the red arrows under the Change Order column to change the sequence in which the guarantors are listed. You may also use the Edit and Delete buttons on the left hand side to edit any information previously entered for a guarantor, or delete the guarantor altogether.

9. Click *Submit* to save the form. The Financial Eligibility pre-display will appear, with each Episode-Based Financial Eligibility listed.

ProviderConnect - Financial Eligibility	SCHMIDT, JILL E. 4/4/2014 1:47:00 PM Lookup Client	Main Menu	Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Episode-Based Financial Eligibility			
Record Date	Admission Date	Episode Number	Agency
4/4/2014 1:19:54 PM	3/7/2014	1	SCHMIDT, JILL E.

10. You may now move forward to ProviderConnect Exercises: Create and Submit Authorization Request for the Client.

ProviderConnect Exercises: Completing the Client Condition – Pregnancy for the Client

Overview

This exercise will demonstrate the user how to complete the Client Condition – Pregnancy form. The Client Condition – Pregnancy form is only required to be completed for clients that are pregnant during the time that treatment is provided.

Training Exercise: Using the Client Condition – Pregnancy Form

1. Click *Client Condition – Pregnancy* on the task bar to open the Client Condition – Pregnancy form.

2. The pre-display for the Client Condition – Pregnancy form will appear. Click *Add Pregnancy Record*.

3. The Client Condition – Pregnancy form will appear. (Red fields and red asterisks indicate that the information is required.)

4. Complete the form via the following steps:
   a. Select the episode number from the Episode Number drop down.
   b. Enter the start date of the client's pregnancy in the Start Date of Pregnancy field.
   c. Enter the end date of the client's pregnancy in the End Date of Pregnancy field.
   d. Enter the initial treatment date of the client's pregnancy in the Initial Treatment Date (2300-DTP-03) field.
   e. Enter the date of client's last menstruation period in the Date of Last Menstruation Period (2300-DTP-03) field.

| Back | **ProviderConnect - Client Condition - Pregnancy** | SCHMIDT, JILL E. 4/9/2014 3:09:04 PM | Lookup Client | Main Menu | Log Out |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Client Condition - Pregnancy

Episode Number
1 - Admit: 3/7/2014 Discharge: Program: x FFS2LE Fee For Service 2 Admission ▼

Start Date of Pregnancy	**End Date of Pregnancy**
10/01/2013	06/30/2014
Initial Treatment Date (2300-DTP-03)	**Date of Last Menstural Period (2300-DTP-03)**
11/01/2013	10/01/2013

Save Changes   Cancel Changes

5. Click *Save Changes* at the bottom of the form to save and submit the form. The Client Condition – Pregnancy pre-display will appear, with each Episode-Based Client Condition – Pregnancy form listed.

| **ProviderConnect - Client Condition - Pregnancy** | SCHMIDT, JILL E. 4/9/2014 3:12:01 PM | Lookup Client | Main Menu | Log Out |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

	Episode	Start Date	End Date	Initial Treatment	Menstrual Date
Edit	1 - Admit: 3/7/2014 Discharge: Program: x FFS2LE Fee For Service 2 Admission	10/01/2013	06/30/2014	11/01/2013	10/01/2013

Add Pregnancy Record

6. You may now move forward to the next training exercise.

ProviderConnect Exercises: Completing the Provider Diagnosis

Overview
This exercise will demonstrate the user how to complete the Provider Diagnosis form for the client. The Provider Diagnosis form is required to be completed for all clients.

Training Exercise: Using the Provider Diagnosis Form

1. Click Provider Diagnosis from the task bar.
2. When the Provider Diagnosis predisplay opens, click *Add Diagnosis Record*.
3. Complete the Provider Diagnosis form via the following steps:
    a. Select the corresponding episode from the Episode Number dropdown.
    b. Select "Admission" from the Type of Diagnosis dropdown.
    c. Enter the Date of Diagnosis.
    d. Enter the Time of Diagnosis.

Diagnosis Information	
Episode Number 1 ▾	**Type of Diagnosis** -Please Choose One- ▾ *
Date of Diagnosis	**Time of Diagnosis** HH:MM AM/PM

　　　　e. Enter the client's diagnosis in the Diagnosis Axis I-1 field.
　　　　f. Enter the client's diagnosis in the Diagnosis Axis I-2 field, if necessary.
　　　　g. Enter the client's diagnosis in the Diagnosis Axis I-3 field, if necessary.
　　　　h. Enter the client's diagnosis in the Diagnosis Axis II-1 field, if necessary.
　　　　i. Enter the client's diagnosis in the Diagnosis Axis II-2 field, if necessary.
　　　　j. Enter the client's diagnosis in the Diagnosis Axis II-3 field, if necessary.
　　　　k. Enter the client's diagnosis in the Diagnosis Axis III-1 field, if necessary.
　　　　l. Enter the client's diagnosis in the Diagnosis Axis III-2 field, if necessary.
　　　　m. Enter the client's diagnosis in the Diagnosis Axis III-3 field, if necessary.
　　　　n. Select the Yes radio button under the Diagnosis Axis IV – Primary Support Group section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.
　　　　o. Select the Yes radio button under the Diagnosis Axis IV – Social Environment section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.
　　　　p. Select the Yes radio button under the Diagnosis Axis IV – Educational section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.
　　　　q. Select the Yes radio button under the Diagnosis Axis IV – Occupational section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.
　　　　r. Select the Yes radio button under the Diagnosis Axis IV – Housing section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.

s. Select the Yes radio button under the Diagnosis Axis IV – Economic section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.

t. Select the Yes radio button under the Diagnosis Axis IV – Health Care Services section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.

u. Select the Yes radio button under the Diagnosis Axis IV – Legal System/Crime section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.

v. Select the Yes radio button under the Diagnosis Axis IV – Other Problems section, and enter a note in the Remarks field. If this section is not applicable, select the No radio button.

Diagnosis Axis I-1	Diagnosis Axis I-2
Diagnosis Axis I-3	Diagnosis Axis II-1
Diagnosis Axis II-2	Diagnosis Axis II-3
Diagnosis Axis III-1	Diagnosis Axis III-2
Diagnosis Axis III-3	Diagnosis Axis IV - Primary Support Group ○ No - N ○ Yes - Y Remarks
Diagnosis Axis IV - Social Environment ○ No - N ◉ Yes - Y Remarks	Diagnosis Axis IV - Educational ○ No - N ○ Yes - Y Remarks
Diagnosis Axis IV - Occupational ○ No - N ○ Yes - Y Remarks	Diagnosis Axis IV - Housing ○ No - N ○ Yes - Y Remarks
Diagnosis Axis IV - Economic ○ No - N ○ Yes - Y Remarks	Diagnosis Axis IV - Health Care Services ○ No - N ○ Yes - Y Remarks
Diagnosis Axis IV - Legal System/Crime ○ No - N ○ Yes - Y Remarks	Diagnosis Axis IV - Other Problems ○ No - N ○ Yes - Y Remarks

w. Select the client's primary diagnosis from the Primary Diagnosis dropdown.

x. Select the appropriate practitioner from the Diagnosing Practitioner dropdown.

y. Enter the client's prognosis in the Prognosis field.

z. Enter the client's approximate discharge date in the Estimated Discharge Date field.

aa. Select the appropriate GAF rating from the Axis V – Current GAF Rating dropdown.

bb. Select the appropriate GAF level from the GAF – Highest Level Last 12 Months dropdown.

cc. Select the appropriate GAF level from the GAF – Lowest Level Last 12 Months dropdown.

dd. Select the appropriate option from the Trauma (CSI) dropdown.

ee. Select the appropriate options from the General Medical Condition Summary Code (CSI) dropdown (select up to three options if necessary).

ff. Select the appropriate option from the Substance Abuse / Dependence (CSI) dropdown.

Principal Diagnosis

-Please Choose One- ▾ *

Diagnosing Practitioner	**Prognosis**
-Please Choose One- ▾ *	[ ]

Estimated Discharge Date

[   ]

Axis V - Current GAF Rating

-Please Choose One- ▾

GAF - Higheset Level Last 12 Months

-Please Choose One- ▾

GAF - Lowest Level Last 12 Months

-Please Choose One- ▾

Trauma (CSI)	**General Medical Condition Summary Code (CSI) (Select Up to Three)**
-Please Choose One- ▾	Allergies - 17 ▲ Anemia - 16 Arterial Sclerotic Disease - 01 Arthritis - 19 ▼ Ctrl+click to choose multiple items (0 currently selected)

Substance Abuse / Dependence (CSI)	**Substance Abuse / Dependence Diagnosis (CSI)**
-Please Choose One- ▾	

Save Diagnosis   Return To List

4. Click *Save Diagnosis* to submit the form.

5. The system will take you back to the Provider Diagnosis pre-display. The provider diagnosis that you created for the client should now be listed in the pre-display.

6. You may now move forward to create an overthreshold authorization request for the client, if one is needed.

ProviderConnect Exercises: Create and Submit an Overthreshold Authorization Request for the Client

Overview

This exercise will demonstrate the user how to create and submit an authorization request that will be sent to Avatar MSO, using the Authorization form, the Over-threshold Authorization Request form, and the Attachments form. The Authorization form is used to create and submit an authorization request for Over-threshold services; the Over-threshold Authorization Request form is used to submit the justification for such services; and the Attachments form is used to submit a signed copy of the Client Care Plan, Initial Assessment, and any other necessary documentation.

As discussed in previous training exercises, the following must be in place in order to move forward with creating an Over-threshold Authorization Request for the client:

- The client must have an existing client record and an open FFS2 admission in IBHIS. If the client does not have an existing client record and FFS2 admission, the provider must create one.
- The client's financial eligibility must be established in the client's record via the Systemwide Annual Liability form and Financial Eligibility form. If the client's financial eligibility has not been established in the client record, please do so before attempting to create the Over-threshold Authorization Request.
- The client's diagnosis must be established in the client's record via the Provider Diagnosis form. If the client's diagnosis has not been established in the client record, please do so before attempting to create the Over-threshold Authorization Request.

Training Exercise: Using the Authorization Form to Create and Submit the Authorization Request

1. Click *Authorizations* from the client's Task Bar.

2. The Authorization Information form will open, displaying existing Authorizations for your agency if any exist. As you can see, this client does not have any existing Authorizations with your agency.

Member ID
3000659

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

ProviderConnect - Authorization Requests   SCHMIDT, JILL E. 4/10/2014 9:07:51 AM   Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
					No records found.						

Create Request

NOTE: Only Authorizations for your agency will appear.

5. Click *Create Request*.

6. The Client Authorization Request Information form sequence will begin.

Authorization Request Information	
Client SSN:	987-44-4444
Agency:	SCHMIDT, JILL E.
Authorization dates: (m/d/yyyy)	
Begin Date:	[ ] Set To [ ] Days Set
End Date:	[ ]
	Request Authorization >>

7. Start by filling out the date range of the request. Enter both *Begin Date* and *End Date*. The *Begin Date* is the date of the first scheduled session for that particular trimester. The *End Date* is the last day of the corresponding trimester.

Authorization Request Information	
Client SSN:	987-44-4444
Agency:	SCHMIDT, JILL E.
Authorization dates: (m/d/yyyy)	
Begin Date:	1/28/2014 Set To [ ] Days Set
End Date:	4/30/2014
	Request Authorization >>

NOTE: The Begin Date and End Date for an Overthreshold Authorization Request should coincide with calendar trimester periods (1st trimester: January 1st – April 30th; 2nd trimester: May 1st – August 31st; 3rd trimester: September 1st – December 31st).

8. Then click *Request Authorization.* The Authorization form will appear. (Red asterisks indicate that the information is required.)

Authorization Request

Client Information		
CLIENT NAME ONE TWO	MEMBER ID 3000659	PROVIDER NAME SCHMIDT, JILL E.

Care Manager	
CARE MANAGER ASSIGNED:	DATE ASSIGNED:

Authorization Information		
AUTHORIZATION NUMBER:	CURRENT AUTHORIZATION STATUS:	CURRENT AUTHORIZATION STATUS REASON:
AUTHORIZED LEVEL OF CARE:	TYPE OF AUTHORIZATION:	PERFORMING PROVIDER TYPE:
PLANNED ADMIT DATE:	INITIAL OR CONTINUING AUTH:	NEXT REVIEW DATE:

Diagnosis	
Primary Diagnosis	
Secondary Diagnosis	

Funding Source & Benefit Plan Information

Funding Source: - Please Choose One - ▼ *	Benefit Plan: - Please Choose One - ▼ *	Provider Registration Date For Funding Source:
Program: - Please Choose One - ▼ *		

Authorization Group
Leave blank for individual CPT Codes requests.
▼

PROCEDURE CODE	UNITS REQUESTED Enter 0 units to ignore added code.
	Add Code

Authorization Dates
Requested: 1/28/2014 - 4/30/2014

9. Enter the client's Primary Diagnosis and Secondary Diagnosis (if available).

Diagnosis	
Primary Diagnosis	311 311 - DEPRESSIVE DISORDER NOS
Secondary Diagnosis	309

309 - Adjustment Disorder With Depressed Mood
309.0 - ADJUSTMENT DISORDER WITH DEPRESSED MOOD
309.21 - SEPARATION ANXIETY DISORDER
309.24 - ADJUSTMENT DISORDER WITH ANXIETY
309.28 - ADJUSTMENT DISORDER WITH ANXIETY AND DEPRESSED MOOD
309.3 - ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT
309.4 - ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT
309.81 - POST-TRAUMATIC STRESS DISORDER
309.9 - ADJUSTMENT DISORDER, UNSPECIFIED

Funding Source & Benefit Plan Information
Funding Source:
- Please Choose One - ▼ *
Program:
- Please Choose One - ▼ *

egistration Date For Funding Source:

Authorization Group
Leave blank for individual CPT Codes requests.
▼

10. Select the Funding Source, Benefit Plan, and Program from the drop downs.

Funding Source & Benefit Plan Information

Funding Source: FFS2 Authorized Outpt Svcs (CGF) MC ▼	Benefit Plan: FFS2 Authorized Outpt Svcs (CGF) MC ▼	Provider Registration Date For Funding Source:
Program: z Schmidt_Jill NR4288620 ▼	- Please Choose One - FFS2 Hospital Professional Services FFS2 Board and Care Prof Svcs FFS2 Authorized Outpt Svcs (CGF) MC	

NOTE: The appropriate Funding Source for Over-threshold services is "FFS2 Authorized Outpt Svcs (CGF) MC." The appropriate Benefit Plan for Over-threshold services is "FFS2 Authorized Outpt Svcs (CGF) MC." The Program refers to your agency; select your agency from the drop down. All the FFS agencies names will start with the letter "z."

11. Now click *Add Code.*

12. In the Procedure Code section, select the appropriate Procedure Code from the drop down and enter a number in the Units Requested field.

PROCEDURE CODE	UNITS REQUESTED Enter 0 units to ignore added code.
90832 - Psychother 30min ff ▾	8 [Remove]
	Add Code

NOTE: A maximum of 8 sessions can be authorized per trimester. Sessions are represented by units in ProviderConnect. Therefore, you can only request up to 8 units per trimester. Please make sure that the units being requested coincide with such regulations.

13. Scroll down to the end of the form, enter comments if you like, and then click *File Request*.

Authorization Dates
Requested: 1/28/2014 - 4/30/2014

File Request

Comments
Comments on Authorization:
1st Overthreshold Authorization Request

Return To Authorization List

14. You will be returned to the Authorization Information form and your new authorization request will appear on the list. Notice that the Authorization Number reads "Unassigned" because Avatar has not yet assigned a number to your authorization request.

ProviderConnect - Authorization Requests   SCHMIDT, JILL E. 9/16/2014 3:54:48 PM   Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	Unassigned	ProviderConnect	z Schmidt_Jill NR4288620	Pending	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		

15. Simply click *Authorizations* on the Task Bar to reload the data. Now you will see that Avatar has received the record, auto assigned the next number your authorization request, and returned the result to Provider Connect.

| ProviderConnect - Authorization Requests | | | | | | | | | SCHMIDT, JILL E. 9/16/2014 3:58:02 PM | | Lookup Client | Main Menu | Log Out |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Add New

Create Request

Authorization Number is assigned.

NOTE: You will need to enter this Authorization Number into the Over-threshold Authorization Form, which is discussed further in the next training exercise.

Training Exercise: Using the Over-threshold Authorization Request Form to Complete the Authorization Request

1. Click *Over Threshold Authorization Request* from the client's Task Bar.

Member ID
3000659

Client Condition - Pregnancy	
Demographic	
CSI Admission	
DCFS Status Tracking	
Financial Eligibility	
Public Guardian Status Tracking	
Authorizations	
Provider Admission	
Provider Diagnosis	
Attachments	
Day Treatment / MHS Authorization Details	
Over Threshold Authorization Request	
Systemwide Annual Liability	
Exit to Main Menu	

ProviderConnect - Authorization Requests — SCHMIDT, JILL E. 9/16/2014 3:58:02 PM — Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Add New

Create Request

About ProviderConnect v2.192

2. The pre-display for the Over Threshold Authorization Request form will open. As you can see, this client does not have any existing Over Threshold Authorization Request Authorizations forms with your agency. Click *Add New Record.*

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Over Threshold Authorization Request Items			
	Date of Request	Authorization Number	Performing Provider

Add New Record

3. The Over-Threshold Authorization Request form will open. (Red fields indicate that the information is required in order to submit the form.)

Print

Over-Threshold Authorization Request

Authorization Number	Desired Outcomes Stated By
	○ Client
	○ Client and Parent/Responsible Adult
	○ Parent/Responsible Adult

Date of Request	Initial Date of Service
[Today] [Yesterday]	[Today] [Yesterday]

Major Barriers/Impairments to Attaining Outcome(s)

Performing Provider
Search for: [   ] [Search]
[   ]

Diagnosis Code
Search for: [   ] [Search]
[   ]

Need for Additional Services

(Attach progress notes from current trimester period, most recent assessment if this is a first OTAR, and any other relevant documentation)

Check One or More of the Following Options and Describe
☐ Decompensation/Marked Functional Decline
☐ Other
☐ Severe Life Crisis
☐ Use of More Costly/Restrictive Setting

Severe Life Crisis Details

Decomposition/Marked Decline in Functioning Details

Use of More Costly/Restrictive Setting Details

NOTE: The Over-threshold Authorization Request form is used to complete the authorization request. The provider must complete all sections in the form when requesting over-threshold services.

4. Complete the Over Threshold Authorization Request form via the following steps:
   a. Enter the system generated Authorization Number that was assigned to the authorization request (as discussed in the previous training exercise) in the Authorization Number field.
   b. Select the appropriate radio button under the Desired Outcomes Stated By section.
   c. Enter the date of completion for the Over Threshold Authorization Request form in the Date of Request field.
   d. Enter the date that the client is scheduled to attend her first session in the Initial Date of Service field.
   e. Enter the client's major barriers and impairments in the Major Barriers/Impairments to Attaining Outcome(s) field.
   f. Search for your provider name by entering the provider's last name or the provider's program of service number under the Performing Provider section, click Search to activate the drop down menu, and select the appropriate name from the drop down menu.

g. Search for the client's diagnosis by entering the appropriate diagnosis or diagnosis number under the Diagnosis Code section, click Search to activate the drop down menu, and select the appropriate diagnosis from the drop down menu.

h. Complete the Need for Additional Services section via the following steps:
   i. Select the Decompensation/Marked Functional Decline, Other, Severe Life Crisis, and Use of More Costly/Restrictive Setting radio buttons to activate the corresponding fields in the Need for Additional Services section. Enter the appropriate information in such fields. (Only select the options and complete the fields that correspond to the client in the Need for Additional Services section.)
   ii. Enter the client's goals in the Goals (Must be specific, observable and quantifiable) field.

i. Complete the Intervention Plan for Requested Services section via the following steps:
   i. Enter the provider's intervention plan in the Provider Intervention Plan field.
   ii. Enter the client's role in the Clients Role field.
   iii. Select the appropriate radio button under the Will Significant Other Partipate? Section. If the Other or Yes radio button is selected, the Describe Participation field is activated, and must be completed before submitting the form.
   iv. Describe the client's significant other's participation in the Describe Participation field, if the Other or Yes radio button was selected.
   v. Enter the name of the significant other in the Name of Significant Other field.
   vi. Select the appropriate radio button under the Medication Evaluation section. If the Yes radio button is selected, the Date field is activated, and the date must be entered before submitting the form.
   vii. Enter the date in the Date field, if the Yes radio button was selected.
   viii. List any other professionals that are currently providing services to the client and describe their roles in the Intervention Partner(s) field.
   ix. Describe the client's progress toward achieving her goals since the date of her last Client Plan in the Progress Toward Goals Since Date of Last Client Plan (OTAR) field.

Over-Threshold Authorization Request

Authorization Number
329

Desired Outcomes Stated By
◉ Client
○ Client and Parent/Responsible Adult
○ Parent/Responsible Adult

Date of Request
12/28/2013 [Today] [Yesterday]

Initial Date of Service
01/28/2014 [Today] [Yesterday]

Major Barriers/Impairments to Attaining Outcome(s)

Enter client's major barriers here.

Performing Provider
Search for: _____ [Search]
(123796) SCHMIDT, JILL ▼

Diagnosis Code
Search for: _____ [Search]
(311) DEPRESSIVE DISORDER NOS ▼

Need for Additional Services

(Attach progress notes from current trimester period, most recent assessment if this is a first OTAR, and any other relevant documentation)

Check One or More of the Following Options and Describe
☑ 1-Severe Life Crisis
☑ 2-Decompensation/Marked Functional Decli
☑ 3-Use of More Costly/Restrictive Setting
☑ 4-Other

Severe Life Crisis Details

Enter the client's severe life crisis details here.

Decomposition/Marked Decline in Functioning Details

Enter the client's decomposition and marked decline in functioning details here.

Use of More Costly/Restrictive Setting Details

Enter the provider's recommendation for use of more costly or restrictive setting here.

Other Details

Enter other client details here.

Goals (Must be specific, observable and quantifiable)

Enter the client's goals here.

Intervention Plan for Requested Services

Provider Intervention Plan

Enter the provider intervention plan here.

Clients Role

Enter the client's role here.

Will Significant Other Participate?
- ○ Not Desired by Client
- ○ Other
- ◉ Yes

Describe Participation

Describe client's significant other's participation here.

Name of Significant Other	**Date**
Blue Green	12/25/2013 [Today] [Yesterday]

Medication Evaluation
- ○ No
- ◉ Yes

Intervention Partner(s) (Note any other professionals currently providing services and their role(s))

List other professionals that are currently providing services to the client and their roles here.

Progress Toward Goals Since Date of Last Client Plan (OTAR)

Enter the client's progress toward achieving her goals since the date of the client's last Client Plan.

[Save Changes]   [Cancel Changes]

5. Click *Save Changes* at the bottom to submit the form.

6. You will be returned to the Over Threshold Authorization Request pre-display, with the new Over Threshold Authorization Request listed. Click *OK* in the pop-up window.

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Over Threshold Authorization Request Items

	Date of Request	Authorization Number	Performing Provider
[Select]	12/28/2013	329	123796

[Add New Record]

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Message from webpage ⚠ Your changes have been saved.   [OK]
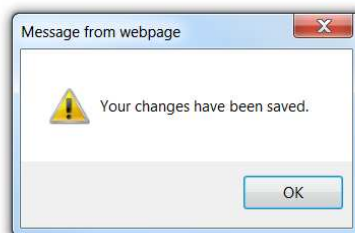
Training Exercise: Using the Over-threshold Authorization Request Form to Print the Authorization Request

1. The next step in this process is to print a hardcopy of the Over Threshold Authorization Request form so that the client and the provider can sign. In the pre-display, click *Select* to open the corresponding Over Threshold Authorization Request form.

2. When the Over Threshold Authorization Request form opens, click *Print* at the top of the form.

3. The system will generate a preview display of the Over Threshold Authorization Request. Click the printer icon, or select *Print…* in the File menu of your browser to print the form.

4. Complete the Consent for Over-threshold Services disclaimer, attach it to the printout of the Over Threshold Authorization Request, and forward such documents to the client for review and signature.

5. Once the client signs the Consent for Over-threshold Services disclaimer, scan these documents and save them to your computer or network using the following name convention: OTAR (Auth #329). Then attach these documents to the authorization request in ProviderConnect, as described in the next training exercise. Please make sure that you include the authorization number in the file name to prevent attaching this documentation to the wrong client record.

Training Exercise: Using the Attachments Form to Attach the Copy of Signed Over Threshold Authorization Request

1. Click *Authorizations* in the task bar to open the Authorization form pre-display.

2. Locate the appropriate authorization request in the pre-display, and click *Add New* from the Attachments column.

ProviderConnect - Authorization Requests									SCHMIDT, JILL E. 9/17/2014 9:18:05 AM	Lookup Client	Main Menu	Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Add New

Create Request

3. The File Attachments form will open. Click *Browse* to locate the scanned copy of the signed Over Threshold Authorization Request in your computer.

ProviderConnect - File Attachments				SCHMIDT, JILL E. 4/10/2014 3:27:22 PM	Lookup Client	Main Menu	Log Out

File Attachments

File Name	Attached By	Date Attached	Notes History	Notes

Add New File Attachment(s):

Note: File Attachments may not be made immediately available

File Name	Notes
Browse...	

Attach New Files

View Authorization

Return to Authorization List

4. Select the appropriate file, and click *Open* to upload the file.

5. Enter the following description in the Notes field: Over-threshold Authorization Request #329. Click *Attach New Files*.

NOTE: Any other supporting documentation must be attached using this form.

6. You will be returned to the Authorization form pre-display.

Training Exercise: Using the Attachments Form to Attach a Copy of the Initial Psychosocial Assessment

1. In addition to the signed copy of the Over Threshold Authorization Request, you must attach a copy of the client's Initial Psychosocial Assessment.

2. Click *Edit/Add New* for the appropriate authorization request.

| ProviderConnect - Authorization Requests | | | SCHMIDT, JILL E. 9/17/2014 9:24:12 AM | Lookup Client | Main Menu | Log Out |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Edit / Add New

Create Request

3. Once the Attachments form opens, click *Browse* to locate the scanned copy of the client's signed Initial Psychosocial Assessment in your computer or network.

| ProviderConnect - File Attachments | | | SCHMIDT, JILL E. 9/17/2014 9:25:23 AM | Lookup Client | Main Menu | Log Out |

File Attachments

	File Name	Attached By	Date Attached	Notes History	Notes
Download	OTAR_Auth_329_.pdf	SCHMIDT1	9/17/2014	View	

Save Changes

Add New File Attachment(s):

Note: File Attachments may not be made immediately available

File Name	Notes
Browse...	

Attach New Files

View Authorization

Return to Authorization List

4. Select the appropriate file, and click *Open* to upload the file.

5. Enter the following description in the Notes field: Initial Psychosocial Assessment (date of initial assessment). Click *Attach New Files*.

6. You will be returned to the Authorization form pre-display.

Training Exercise: Using the Attachments Form to Attach a Copy of the Progress Notes

1. In addition to the copy of the client's Initial Psychosocial Assessment, you must attach a copy of the client's Progress Notes.

2. Click *Edit/Add New* for the appropriate authorization request.

ProviderConnect - Authorization Requests   SCHMIDT, JILL E. 9/17/2014 9:24:12 AM   Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Edit / Add New

Create Request

3. Once the Attachments form opens, click *Browse* to locate the scanned copy of the client's Progress Notes in your computer or network.

ProviderConnect - File Attachments   SCHMIDT, JILL E. 9/17/2014 9:53:02 AM   Lookup Client | Main Menu | Log Out

File Attachments

	File Name	Attached By	Date Attached	Notes History	Notes
Download	Initial_Psychosocial_Assessment__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes
Download	OTAR__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes

Add New File Attachment(s):

Note: File Attachments may not be made immediately available

File Name	Notes
Browse...	

Attach New Files

4. Select the appropriate file, and click *Open* to upload the file.

View Authorization

Return to Authorization List

5. Enter the following description in the Notes field: Progress Notes (date of progress notes). Click *Attach New Files*.

View Authorization

Return to Authorization List

6. You will be returned to the Authorization form pre-display.

NOTE: Any other relevant documentation pertaining to the client's particular authorization request should be attached to the authorization request via this form, as explained in this section.

Training Exercise: Using the Attachments Form to Attach a Copy of the Signed Informed Consent to Release Information Form

1. In addition to the copy of the client's Progress Notes, you must attach a signed copy of the client's Informed Consent to Release Medical Information form if the client has Medi-Cal.

2. Click *Edit/Add New* for the appropriate authorization request.

| ProviderConnect - Authorization Requests | SCHMIDT, JILL E. 9/17/2014 9:24:12 AM | Lookup Client | Main Menu | Log Out |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

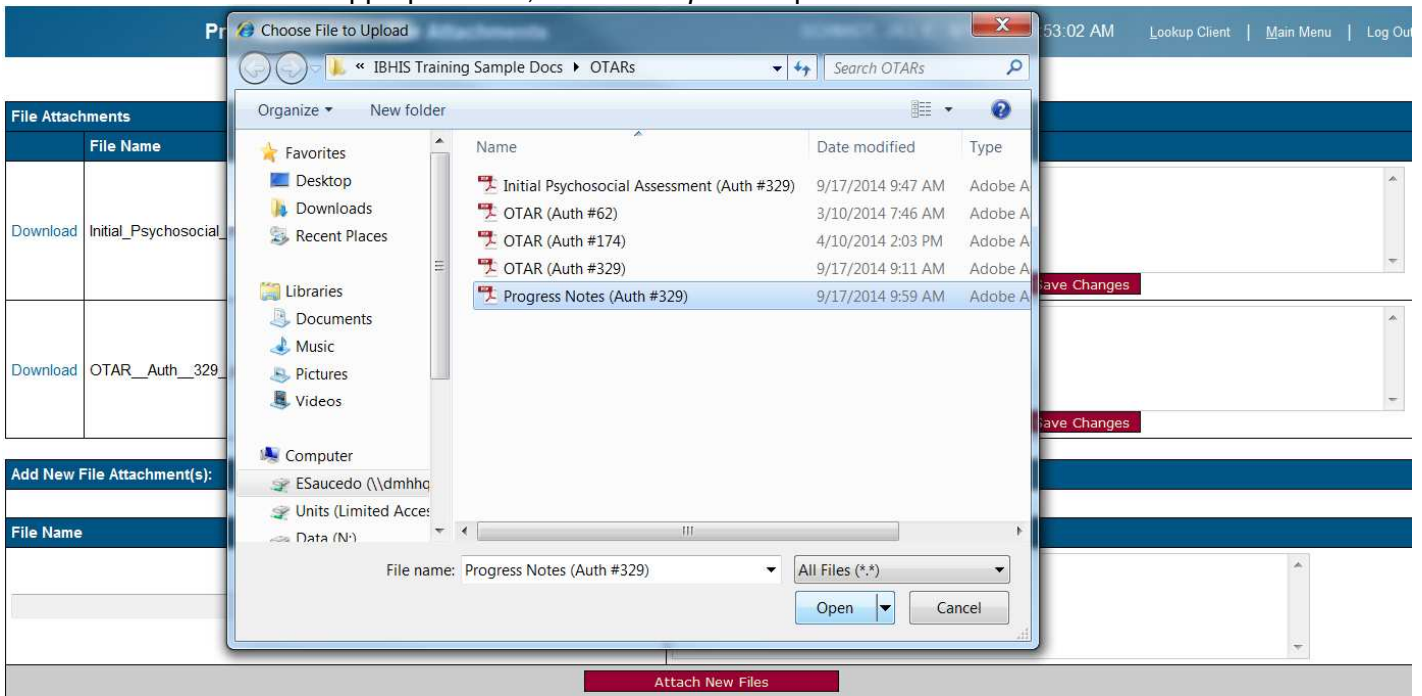| Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Edit / Add New

Create Request

3. Once the Attachments form opens, click *Browse* to locate the scanned copy of the client's signed Informed Consent to Release Medical Information form in your computer or network.

File Attachments

	File Name	Attached By	Date Attached	Notes History	Notes
Download	Progress_Notes__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes
Download	Initial_Psychosocial_Assessment__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes
Download	OTAR__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes

Add New File Attachment(s):

Note: File Attachments may not be made immediately available

File Name	Notes
Browse...	

Attach New Files

4. Select the appropriate file, and click *Open* to upload the file.

5. Enter the following description in the Notes field: Informed Consent to Release Medical Information (date of signature). Click *Attach New Files*.

6. You will be returned to the Authorization form pre-display.

ProviderConnect Exercises: Checking the Authorization Status and Reviewing NOA Letters

Overview

This exercise will demonstrate the user how to check the status of the authorization request and review Notice of Action (NOA) letters, using the Authorization form, and the File Attachments form, respectively.

Training Exercise: Using the Authorizations Form to Check the Status of the Authorization Request

1. Click Authorizations in the task bar to open the Authorizations pre-display. Locate the appropriate authorization request and review the Review Status column. This column provides a status update for the authorization request. Once the Central Authorization Unit has completed its review of the particular authorization request, the status in the in Review Status column will change from Not Reviewed to Approved, or Denied.

| ProviderConnect - Authorization Requests | | SCHMIDT, JILL E. 9/17/2014 9:24:12 AM | Lookup Client | Main Menu | Log Out |

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		💾 Edit / Add New

Create Request

2. Click on the authorization number to open the authorization request and view a full description of the Central Authorization Unit's decision. Verify the Current Authorization Status section and the Current Authorization Status Reason section. The status in the Current Authorization Status section will inform you if the authorization request has been approved or denied by the department. The status in the Current Authorization Status Reason section provides a description of the status.

ProviderConnect - Authorization Request	SCHMIDT, JILL E. 9/17/2014 10:26:51 AM	Lookup Client	Main Menu	Log Out

Authorization Request
Approved

Client Information		
CLIENT NAME ONE TWO	**MEMBER ID** 3000659	**PROVIDER NAME** SCHMIDT, JILL E.

Care Manager	
CARE MANAGER ASSIGNED: e517445	**DATE ASSIGNED:** 12/29/2013

Authorization Information		
AUTHORIZATION NUMBER: 329	**CURRENT AUTHORIZATION STATUS:** A - Approved	**CURRENT AUTHORIZATION STATUS REASON:** APPRPART - Authorization Request Partially Approved
AUTHORIZED LEVEL OF CARE:	**TYPE OF AUTHORIZATION:** 11 - Managed Care - Over-threshold	**PERFORMING PROVIDER TYPE:**
PLANNED ADMIT DATE:	**INITIAL OR CONTINUING AUTH:**	**NEXT REVIEW DATE:**

NOTE: It is extremely important that you verify the Current Authorization Status Reason section. Full approvals and partial approvals will show as Approved in the Current Authorization Status field. The Current Authorization Status Reason section is the only way to distinguish between a full approval and a partial approval.

3. As you can see from the screenshot above, this authorization was only partially approved by the Central Authorization Unit. Scroll down to the bottom of the form and review the Units Requested and Units Authorized fields. Notice that the amount of Units Authorized differ from the amount of Units Requested. This means that the Central Authorization Unit only authorized 4 sessions, instead of the 8 sessions that were initially requested.

PROCEDURE CODE	DESCRIPTION	UNITS REQUESTED	UNITS AUTHORIZED
90832	Psychother 30min ff	8	4

Authorization Dates
Requested: 1/28/2014 - 4/30/2014
Authorized: 1/28/2014 - 4/30/2014

Comments
Authorization Comments:
1st Overthreshold Authorization Request

Return To Authorization List

NOTE: If the authorization request is partially approved or denied, scroll down to the bottom of the form and review the Units Requested field and the Units Authorized field.

4. Click *Return to Authorization List* to return to the Authorizations pre-display.

Training Exercise: Using the Attachments Form to Review NOA Letters

1. LACDMH is required to send an NOA letter to a client, and send a copy of the NOA to the provider, when authorization requests have been partially approved or denied. The Central Authorization Unit attaches the NOA to the corresponding authorization request for the provider's records.

2. Being that this authorization request was partially approved, the next step is to review the Notice of Action (NOA) letter that has been attached to the authorization request by the Central Authorization Unit. Locate the appropriate authorization request from the Authorization pre-display, and click *Edit/Add New*.

ProviderConnect - Authorization Requests   SCHMIDT, JILL E. 9/17/2014 9:24:12 AM   Lookup Client | Main Menu | Log Out

Client Name:	TWO, ONE
Member ID:	3000659
SSN:	987-44-4444

Authorization Information

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date	Begin Date	Expiration Date	Tx Codes	Attachments
SCHMIDT, JILL E.	329	ProviderConnect	z Schmidt_Jill NR4288620	Complete	Not Reviewed	9/16/2014 6:54:48 PM	9/16/2014 2:54:48 PM	1/28/2014	4/30/2014		Edit / Add New

Create Request

3. Once the Attachments form opens, locate the NOA or Notice of Action Letter and click *Download* next to the file name to view the NOA.

ProviderConnect - File Attachments   SCHMIDT, JILL E. 9/17/2014 10:50:23 AM   Lookup Client | Main Menu | Log Out

File Attachments

	File Name	Attached By	Date Attached	Notes History	Notes
Download	Progress_Notes__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes
Download	Initial_Psychosocial_Assessment__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes
Download	OTAR__Auth__329_.pdf	SCHMIDT1	9/17/2014	View	Save Changes
Download	notice of action letter (auth #329).pdf		9/17/2014	View	Save Changes

4. The NOA will open for review.

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Medi-Cal Specialty Mental Health Services Program

Notice of Action Letters

NOA B: Denial/Modification of Authorization

Date: 9/17/2014   Form Status: Final

Responsible Practitioner: SCHMIDT,JILL   Program Issuing NOA: LE00019 LA County DMH

To: ONE TWO   Medical Number:

Is this NOA Associated with an MSO Authorization : Yes

Associated MSO Auth #: 329

Is this NOA Associated with Other Auth Request Type : Other

Reference Number: 329

Other Authorization Request Type :

The mental health plan for Los Angeles County has Changed your provider's request for payment of the

following service(s):

Overthreshold

The request was made by: Jill Schmidt

The original request from your provider was dated 12/28/2013

The mental health plan took this action based on information from your provider for the reason(s) shown below:

● Other

Your documentation does not provide enough clinical justification for 8 over-threshold sessions.
We are willing to approve 4 sessions for the trimester specified to assist the client in her transition
out of treatment.

If you don't agree with the plan's decision, you may:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental
health plan at (213)738-4949 or write to: Patients' Rights Office, 550 S. Vermont Ave., Los Angeles, CA 90020 Attn: Beneficiary
Services Program, or follow the direction in the information brochure the mental health plan has given you. You must file an
appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal,
which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health,
including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay
the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this
notice or before the effective date of the change in services, whichever is later. The services requested were previously
approved by the plan for the period 1/28/2014 to 4/30/2014. the effective date for the change in these services is 12/31/2013.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which my allow services to continue
while you wait for the hearing. The last page of this notice explains how to request a state hearing. You can request that your
services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the
date of this notice or before the effective date of the change in services, whichever is later. The services requested were
previously approved by the plan for the period 1/28/2014 to 4/30/2014. The effective date for the change in these services is
12/31/2013. The services may continue while you wait for the resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about mental health condition. To do this, you may call and talk to a
representative of our mental health plan at (213)738-4949 or write to: Patients' Rights Office, 550 S. Vermont Ave., Los Angeles,
CA 90020 Attn: Beneficiary Services Program.

NOA-B (revised 6-1-05)

Page 1 of 2

Hope, Wellness and Recovery... connecting people, ideas and resources...

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

ProviderConnect Exercises: FFS Provider Readiness Claims Testing

Overview and Purpose

The purpose of this section is to prepare FFS providers for Provider Readiness Claims Testing, and assist FFS providers with creating test clients and associated financial eligibility records to support the submission of claims for the following testing scenarios: Medi-Cal client, Medi-Medi client, OHC-Medi-Cal client. In addition, requesting an authorization for Over-threshold services is also included in the scope of this testing. This section provides a step-by-step outline of phase 2 and 3 in the FFS Claims Certification Testing Script, which FFS providers must use as a guide to complete their claiming test scenarios. The FFS Claims Certification Testing Script is posted on the IBHIS Readiness page of the IS website at the following web address: http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Readiness.htm. All information provided in this section is covered in the previous ProviderConnect training exercises in further detail.

Each Phase 2 section will guide you through the process of creating a record and an admission for a test client in ProviderConnect, as well as completing the financial eligibility forms for each test client. You will create three test clients in total; one client with Medi-Cal; one client with Medicare and Medi-Cal; and one client with other healthcare coverage and Medi-Cal. The Phase 3 section will guide you through the process of creating an Overthreshold Authorization Request for one of the test clients that you created as part of Phase 2. You will be required to choose one of the three clients that you created, and create an Overthreshold Authorization Request for that client.

Phase 2 Claiming Test Scenario: *Medi-Cal Client*

1. Create an Admission for a new test client.

   a. Select *Add New Client/Client Search* from Main Menu.

   b. Enter "Last Name", "First Name" and "Sex" and Select *Search.*

c. Select *Create Admission for New Client* after search returned no client records.

d. In the Admission form, enter the following information into their corresponding fields.

Provider Connect Field	Data to be Entered
Gender	F
Date of Birth	3/1/1985
Admission Date	12/1/2013
Admission Time	11:55 AM
Program	xFFS2LE Fee for Service 2 Admission
Admitting Practitioner	(Enter the Practitioner ID)*
Type of Admission	FirstAdmission
Social Security Number	987126666
Client First Name	(Enter the Client First Name)*~
Client Last Name	(Enter the Client Last Name)*~
Street Address 1	101 Anywhere Street
Street Address 2	Apt. 10
ZIP Code	90005
City	Los Angeles
State	CA

* Identified by Provider
~ Client name should be obviously fictitious (e.g. first name = Blue, last name = Sky)

e. Select *Save Admission* (located at the bottom of the form) after entering all of the above information.

2. Create Financial Eligibility for the new test client.

    a. Search for client (entered in step 1 above) via Lookup Client from Main Menu.

Main Menu - Provider		
Lookup Client	**Add New Client/Client Search**	**Change Password**
Documentation	**News**	

Logout / Exit

    b. Enter client First Name and Last Name and Select *Search by Criteria*.

Search Criteria	
Member ID:	
SSN:	
First Name:	Testing
Last Name:	Testing
Date of Birth:	
Agency:	

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

    c. Select the link Client ID when the client appears in your search results.

Search Results				
Client ID	**Last Name**	**First Name**	**Date of Birth**	**Agency**
3003251	Testing	Testing	3/1/1985	

    d. Select *Financial Eligibility* from the task bar.

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

e. Select *Add Financial Eligibility* from the Financial Eligibility predisplay.

Episode-Based Financial Eligibility			
Record Date	**Admission Date**	**Episode Number**	**Agency**
No records found.			

Add Financial Eligibility ⬅

f. Select the Episode Number dropdown.

Financial Eligibility	
Episode Number	[▼] ⬅
Admission Date	[ ]
Program	[ ]
Default Information from Different Episode	○ Yes - Y ○ No - N
Episode To Default From	[▼]
Coverage Comments	[ ]

g. Select the Episode Number for the Fee-for-Service Admission.

Episode Selection				x
Episode Number	**Admit Date**	**Discharge Date**	**Program**	
1 ⬅	12/1/2013		x FFS2LE Fee For Service 2 Admission	

h. Select *No* to Default Information from Different Episode.

Default Information from Different Episode	○ Yes - Y ◉ No ⬅

i. Select "Medi-Cal (10)" from the Guarantor Selection dropdown list, and select *Add Guarantor.*

Guarantor Selection	
Medi-Cal (10) [▼]	**Add Guarantor** ⬅

j. In the Guarantor Details form, enter the following data into their corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	101 Anywhere Street*
Subscriber Address 2	Apt. 10*
Subscriber City	Los Angeles*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	987126666*
Subscriber Sex	F*
Subscriber Policy Number	92312312A
Subscriber Client Index Number	92312312A
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Informed Consent To Release Medical Info - I
Eligibility Verified:	Yes
Coverage Effective Date	9/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields, to avoid entering the information manually.

k. Select *Save* after entering the information above.

l. Select "LA County (16)" from Guarantor Selection dropdown list, and select *Add Guarantor*.

m. In the Guarantor Details form, enter the following data into their corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	101 Anywhere Street*
Subscriber Address 2	Apt. 10*
Subscriber City	Los Angeles*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	987126666*
Subscriber Sex	F*
Subscriber Policy Number	91233445A
Subscriber Client Index Number	91233445A
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Yes, Provider Has Signed Statement Permitting Release
Eligibility Verified	Yes
Coverage Effective Date	9/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

n. Select *Save* after entering the information above.

o. Verify that the DMH guarantor (otherwise known as the Medi-Cal guarantor) is listed first, and the LA County guarantor is listed second in the Guarantor Selection section. Then select *Submit* to save the client's financial eligibility information.

p. The Financial Eligibility predisplay will appear, confirming the submission of the client's financial eligibility.

Episode-Based Financial Eligibility		
Record Date	Admission Date	Episode Number
9/17/2014 1:46:00 PM	12/1/2013	1

Phase 2 Claiming Test Scenario: *Medi-Medi Client*

1. Create an Admission for the new test client.

   a. Select *Add New Client/Client Search* from Main Menu.

Main Menu - Provider		
Lookup Client	Add New Client/Client Search	Change Password
Documentation	News	
Logout / Exit		

   b. Enter "Last Name," "First Name" and "Sex" and select *Search*.

Search Criteria	
Social Security Number:	
Last Name:	NAME
First Name:	NAME
Sex:	◉ Female - F ○ Male - M ○ Other - O ○ Unknown - U
Date of Birth:	

   Search

   c. Select Create Admission for New Client after search returned no client records.

Search Criteria	
Social Security Number:	
Last Name:	NAME
First Name:	NAME
Sex:	◉ Female - F ○ Male - M ○ Other - O ○ Unknown - U
Date of Birth:	

   Search

   No clients found.

   Create Admission for New Client

d. In the Admission form, enter the following information into their corresponding fields.

Provider Connect Field	Data to be Entered
Gender	F
Date of Birth	9/1/1945
Admission Date	10/1/2013
Admission Time	2:00 PM
Program	xFFS2LE Fee for Service 2 Admission
Admitting Practitioner	(Enter the Practitioner ID)*
Type of Admission	FirstAdmission
Social Security Number	989111111
Client First Name	(Enter the Client First Name)*~
Client Last Name	(Enter the Client Last Name)*~
Street Address 1	999 Anywhere Street
Street Address 2	Apt 9
ZIP Code	90005
City	Los Angeles
State	CA

* Identified by Provider
~ Client name should be obviously fictitious (e.g. first name = Blue, last name = Sky) and different than the Medi-Cal test client.

e. Select *Save Admission* (located at the bottom of the form) after entering all of the above information.

Save Admission

2. Create Financial Eligibility for the new test client.

a. Search for client (entered in step 1 above) via Lookup Client from Main Menu.

Main Menu - Provider		
Lookup Client	Add New Client/Client Search	Change Password
Documentation	News	
Logout / Exit		

b. Enter client First Name and Last Name and select *Search by Criteria*.

Search Criteria	
Member ID:	
SSN:	
First Name:	NAME
Last Name:	NAME
Date of Birth:	
Agency:	SCHMIDT, JILL E.

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

c. Select the link Client ID when the client appears in your search results.

Search Results				
Client ID	Last Name	First Name	Date of Birth	Agency
3006172	NAME	NAME	9/1/1945	SCHMIDT, JILL E.

d. Select *Financial Eligibility* from the task bar.

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

e. Select *Add Financial Eligibility* from the Financial Eligibility predisplay.

Episode-Based Financial Eligibility			
Record Date	Admission Date	Episode Number	Agency
No records found.			

Add Financial Eligibility

f. Select the Episode Number dropdown.

Financial Eligibility	
Episode Number	[▼] ⬅
Admission Date	[ ]
Program	[ ]
Default Information from Different Episode	○ Yes - Y ○ No - N
Episode To Default From	[▼]
Coverage Comments	[ ]

g. Select the Episode Number for the Fee-for-Service Admission.

Episode Selection				X
Episode Number	Admit Date	Discharge Date	Program	
1 ⬅	10/1/2013		x FFS2LE Fee For Service 2 Admission	

h. Select *No* to Default Information from Different Episode.

Default Information from Different Episode	○ Yes - Y ◉ No ⬅

i. Select "Medicare (12)" from Guarantor Selection list and select *Add Guarantor*.

Guarantor Selection
Medicare (12) [▼]   [Add Guarantor] ⬅

j. In the Guarantor Details form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	999 Anywhere Street*
Subscriber Address 2	Apt 9*
Subscriber City	Los Angeles*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	989111111*
Subscriber Sex	F*
Subscriber Policy Number	15830AC
Subscriber Medicare Number	LD840658
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Yes, Provider Has Signed Statement Permitting Release - Y
Eligibility Verified	Yes
Coverage Effective Date	9/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

k. Select *Save* after entering the information above.

l. Select "Medi-Cal (10)" from Guarantor Selection dropdown list and select *Add Guarantor*.

m. In the Guarantor Details form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	999 Anywhere Street*
Subscriber Address 2	Apt 9*
Subscriber City	Los Angeles*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	989111111*
Subscriber Sex	F*
Subscriber Policy Number	95612312A
Subscriber Client Index Number	95612312A
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Informed Consent To Release Medical Infor – I
Eligibility Verified:	Yes
Coverage Effective Date	9/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

n. Select *Save* after entering the information above.

o. Select "LA County (16)" from Guarantor Selection dropdown list and select *Add Guarantor*.

p. In the Guarantor Details form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	999 Anywhere Street*
Subscriber Address 2	Apt 9*
Subscriber City	Los Angeles*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	989111111*
Subscriber Sex	F*
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Yes, Provider Has Signed Statement Permitting Release
Eligibility Verified	Yes
Coverage Effective Date	9/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

q. Select *Save* after entering the information above.

r. Verify that the Noridian guarantor (otherwise known as the Medicare guarantor) is listed first, the DMH guarantor (otherwise known as the Medi-Cal guarantor) is listed second, and the LA County guarantor is listed third in the Guarantor Selection section. Then select *Submit* to save the client's financial eligibility information.

s. The Financial Eligibility predisplay will appear, confirming the submission of the client's financial eligibility.

Phase 2 Claiming Test Scenario: *OHC- Medi-Cal Client*

1. Create an Admission for the new test client. .

   a. Select *Add New Client/Client Search* from the Main Menu.

Main Menu - Provider		
<u>L</u>ookup Client	Add New Client/Client Search	Change Password
Documentation	News	
Logout / Exit		

   b. Enter Last Name, First Name and Sex, and select *Search*.

Search Criteria	
Social Security Number:	
Last Name:	STICKER
First Name:	STICKER
Sex:	○ Female - F ◉ Male - M ○ Other - O ○ Unknown - U
Date of Birth:	

   Search

   c. Select *Create Admission for New Client* after search returned no client records.

Search Criteria	
Social Security Number:	
Last Name:	STICKER
First Name:	STICKER
Sex:	○ Female - F ◉ Male - M ○ Other - O ○ Unknown - U
Date of Birth:	

   Search

   No clients found.

   Create Admission for New Client

d. In the Admission form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Gender	M
Date of Birth	10/1/1976
Admission Date	12/12/2013
Admission Time	10:00 AM
Program	xFFS2LE Fee for Service 2 Admission
Admitting Practitioner	(Enter the Practitioner ID)*
Type of Admission	First Admission
Social Security Number	999222222
Client First Name	(Enter the Client First Name)*~
Client Last Name	(Enter the Client Last Name)*~
Street Address 1	555 Anywhere Street
Street Address 2	Apt 5
ZIP Code	90005
City	Los Angeles
State	CA

* Identified by Provider
~ Client name should be obviously fictitious (e.g. first name = Blue, last name = Sky) and different than the Medi-Cal and Medi-Medi test clients.

e. Select *Save Admission* (located at the bottom of the form) after entering all of the above information.

Save Admission

2. Create Financial Eligibility for the new test client.

    a. Search for the client (entered in step 1 above) via Lookup Client from the Main Menu.

Main Menu - Provider		
Lookup Client	**Add New Client/Client Search**	**Change Password**
Documentation	**News**	
Logout / Exit		

    b. Enter the First Name and Last Name, and select *Search by Criteria*.

Search Criteria	
Member ID:	
SSN:	
First Name:	STICKER
Last Name:	STICKER
Date of Birth:	
Agency:	SCHMIDT, JILL E.

Note: Only clients with authorization requests, pended or approved authorizations, and/or provider-initiated Admissions will display.

Search by Criteria

    c. Select the link Client ID when the client appears in your search results.

Search Results				
Client ID	**Last Name**	**First Name**	**Date of Birth**	**Agency**
3006182	STICKER	STICKER	10/1/1976	SCHMIDT, JILL E.

    d. Select *Financial Eligibility* from the task bar.

Client Condition - Pregnancy
Demographic
CSI Admission
Financial Eligibility
Authorizations
Provider Admission
Provider Diagnosis
Attachments

    e. Select Add Financial Eligibility from the Financial Eligibility predisplay.

Episode-Based Financial Eligibility			
Record Date	**Admission Date**	**Episode Number**	**Agency**
No records found.			

Add Financial Eligibility

f. Select the Episode Number dropdown.

Financial Eligibility	
Episode Number	[▼] ⬅
Admission Date	[ ]
Program	[ ]
Default Information from Different Episode	○ Yes - Y ○ No - N
Episode To Default From	[▼]
Coverage Comments	[ ]

g. Select the Episode Number for the Fee-for-Service Admission.

Episode Selection				[X]
Episode Number	**Admit Date**	**Discharge Date**	**Program**	
1 ⬅	12/12/2013		x FFS2LE Fee For Service 2 Admission	

h. Select No to Default Information from Different Episode.

Default Information from Different Episode	○ Yes - Y ⦿ No - N ⬅

i. Select the applicable OHC payor from the Guarantor Selection dropdown list, and select *Add Guarantor*. Below is a partial list of the potential payors that might be selected.

Capitol Administrators (50)
Care 1st Health Plan - POB4239 (66)
Care 1st Health Plan - Potrero (49)
Caremore Insurance - POB 366 (51)
CDPHP (151)
Cedar Sinai - POB 6250 (52)
Cedar Sinai (Secure Horizons) (53)
Centinela Valley IPA Medical Group (69)
Central Health Medicare Plan (54)
Champ VA - Submit Denied Claims (56)
Champ VA Insurance Claims (55)
CHAMPUS/Tricare Resubmitted Claims (57)
Choc Health Alliance - POB 62108 (58)
Cigna Behavioral Health - POB 188022 (59)
Cigna Healthcare (PPO) Greatwest (60)
Cigna Insurance - POB 46270 (61)
Cigna Insurance - POB 5200 (62)
Citizens Choice Health Plans - POB 127 (63)
Clinica Medica San Miguel IPA (70)
Coast Healthcare Management (74)
College of Health IPA - Pioneer Blvd (64)
Community Family Care - POB2002 (65)
Community Health Plan - Fremont Bldg (67)
CompCare-MLK Blvd (68)
Coventry Healthcare - UBH (77)
CSM Default Payor (99999)
Directors Guild of America (71)
Easy Choice Health Plan - POB 260519 (72)
EHS Medical Group - POB 2002 (73)
Facey Medical Foundation - POB 9605 (75)

Cigna Insurance - POB 46270 (61) [▼]   [Add Guarantor] ⬅

j. In the Guarantor Details form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	555 Anywhere Street*
Subscriber Address 2	Apt 5*
Subscriber City	90005*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	999222222*
Subscriber Sex	M*
Subscriber Policy Number	9999830AC
Subscriber Client Index Number	99990658C
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Yes, Provider Has Signed Statement Permitting Release
Eligibility Verified	Yes
Coverage Effective Date	10/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

k. Select *Save* after entering the information above.

l. Select "Medi-Cal (10)" from Guarantor Selection dropdown list, and select *Add Guarantor*.

m. In the Guarantor Details form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	555 Anywhere Street*
Subscriber Address 2	Apt 5*
Subscriber City	90005*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	999222222*
Subscriber Sex	M*
Subscriber Policy Number	98798798A
Subscriber Client Index Number	98798798A
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Informed Consent To Release Medical Info – I
Eligibility Verified	Yes
Coverage Effective Date	10/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

n. Select *Save* after entering the information above.

o. Select "LA County (16)" from Guarantor Selection dropdown list, and select *Add Guarantor*.

p. In the Guarantor Details form, enter the following information in the corresponding fields.

Provider Connect Field	Data to be Entered
Customize Guarantor Plan	No
Subscriber's Name	(Enter the Client Name from Admission (Last,First MI))*
Client's Relationship to Subscriber	Self
Subscriber Address	555 Anywhere Street*
Subscriber Address 2	Apt 5*
Subscriber City	90005*
Subscriber State	CA*
Subscriber Zip	90005*
Subscriber Social Security Number	999222222*
Subscriber Sex	M*
Subscriber Assignment of Benefits	Yes
Subscriber Release of Information	Yes, Provider Has Signed Statement Permitting Release
Eligibility Verified:	Yes
Coverage Effective Date	10/1/2013
Coordination of Benefits	Yes

*Selecting "Self" from the Client's Relationship to Subscriber dropdown will prepopulate these fields.

q. Select *Save* after entering the information above.

r. Verify that the OHC guarantor (Capitol Administrators, Blue Cross, Kaiser, etc.) is listed first, the DMH guarantor (otherwise known as the Medi-Cal guarantor) is listed second, and the LA County guarantor is listed third in the Guarantor Selection section. Then select *Submit* to save the client's financial eligibility information.

s. The Financial Eligibility predisplay will appear, confirming the submission of the client's financial eligibility.

Phase 3 Claiming Test Scenario: *Creating an Over-threshold Authorization Request*

1. Choose *one* of the three test clients that you created in Phase 2, and then search for the client via the Lookup Client search feature.

2. Open the client record, and select *Authorizations* from the task bar:

| |
|---|
| Client Condition - Pregnancy |
| Demographic |
| CSI Admission |
| DCFS Status Tracking |
| Financial Eligibility |
| Public Guardian Status Tracking |
| Authorizations |
| Provider Admission |
| Provider Diagnosis |
| Attachments |

3. Click *Create Request*.

Provider	Auth Number	Origin	CP Program	Status	Review Status	Request Date	Review Date
						No records found.	

Create Request

4. Then enter the Begin Date and End Date for the authorization, and select *Request Authorization*. Make sure that the dates fall in line with the date of service that will be entered in the claim. Then click *Request Authorization.*

Authorization Request Information	
Client SSN:	
Agency:	.
Authorization dates: (m/d/yyyy)	
Begin Date: 1/1/2014	Set To [ ] Days Set
End Date: 4/30/2014	
	Request Authorization >>
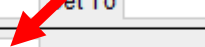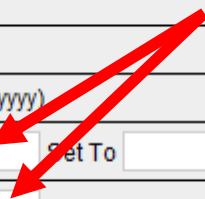
3. The Authorization form will appear. (Red asterisks indicate that the information is required.)

Client Information		
CLIENT NAME ADMISSION TEST	MEMBER ID 3006083	PROVIDER NAME SCHMIDT, JILL E.

Care Manager		
CARE MANAGER ASSIGNED:		DATE ASSIGNED:

Authorization Information		
AUTHORIZATION NUMBER:	CURRENT AUTHORIZATION STATUS:	CURRENT AUTHORIZATION STATUS REASON:
AUTHORIZED LEVEL OF CARE:	TYPE OF AUTHORIZATION:	PERFORMING PROVIDER TYPE:
PLANNED ADMIT DATE:	INITIAL OR CONTINUING AUTH:	NEXT REVIEW DATE:

Diagnosis

Primary Diagnosis

Secondary Diagnosis

Funding Source & Benefit Plan Information

Funding Source: *

- Please Choose One -

Benefit Plan: *

- Please Choose One -

Provider Registration Date For Funding Source:

Program: *

- Please Choose One -

Authorization Group
Leave blank for Individual CPT Codes requests.

PROCEDURE CODE

UNITS REQUESTED
Enter 0 units to ignore added code.

Add Code

Authorization Dates

Requested: 1/1/2014 - 4/30/2014

File Request

4. Enter the client's Primary Diagnosis.

Diagnosis

Primary Diagnosis — 309

- 309.0 - ADJUSTMENT DISORDER WITH DEPRESSED MOOD
- 309.21 - SEPARATION ANXIETY DISORDER
- 309.24 - ADJUSTMENT DISORDER WITH ANXIETY
- 309.28 - ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD
- 309.3 - ADJUSTMENT DISORDER WITH DISTURBANCE OF OF CONDUCT
- 309.4 - ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AND CONDUCT
- 309.81 - POSTTRAUMATIC STRESS DISORDER
- 309.9 - ADJUSTMENT DISORDER UNSPECIFIED

Secondary Diagnosis

Funding Source & Benefit Plan Information

Funding Source: *

- Please Choose One -

Benefit Plan: *

- Please Choose One -

Program: *

- Please Choose One -

Authorization Group
Leave blank for Individual CPT Codes requests.

5. Select the Funding Source, Benefit Plan, and Program from the drop downs.

Funding Source & Benefit Plan Information

Funding Source:	Benefit Plan:	Provider Registration Date For Funding Source:
FFS2 Authorized Outpt Svcs (CGF) MC	FFS2 Authorized Outpt Svcs (CGF) MC	

Program:
z Your_Agency_Name

Note: The appropriate Funding Source for Over-threshold services is "FFS2 Authorized Outpt Svcs (CGF) MC." The appropriate Benefit Plan for Over-threshold services is "FFS2 Authorized Outpt Svcs (CGF) MC." The Program refers to your agency; select your agency from the drop down. All FFS agency names will start with the letter "z."

6. Now click *Add Code* in the Procedure Code section. Select the appropriate Procedure Code from the drop down and enter the number of Units Requested.

PROCEDURE CODE	UNITS REQUESTED Enter 0 units to ignore added code.	
90847:59 - Family Therapy w/ Client Dupl (:59) ▾	8	Remove
Add Code		

7. Enter the following comment in the *Comments on Authorization* field: "OTAR for claims testing."

Comments
Comments on Authorization:
OTAR for claims testing.

8. Click *File Request* to submit the request.

Authorization Dates
Requested: 1/1/2014 - 4/30/2014

File Request

9. You will be returned to the Authorization Information form and your new authorization request will appear on the list. Notice that the Authorization Number is "Unassigned" because Avatar has not yet assigned a number to your authorization request.

Authorization Information								
Provider	Auth Number	CP Program	Status	Review Status	Request Date	Begin Date	Expiration Date	Attachments
Your Name	Unassigned	...me	Pending	Not Reviewed	8/5/2014 2:52:16 PM	1/1/2014	4/30/2014	

10. Refresh your screen by selecting *Authorizations* from the task bar.

Client Condition - Pregnancy
Demographic
CSI Admission
DCFS Status Tracking
Financial Eligibility
Public Guardian Status Tracking
Authorizations
Provider Admission
Provider Diagnosis
Attachments

11. You will now see the "Authorization Number" that Provider Connect has assigned to your request.

Authorization Information

Provider	Auth Number	CP Program	Status	Review Status	Request Date	Begin Date	Expiration Date	Attachments
Your Name	298	Name	Complete	Not Reviewed	8/5/2014 2:52:16 PM	1/1/2014	4/30/2014	

12. Contact DMH's Central Authorizations Unit (CAU) via e-mail to notify the department that your authorization request for claims testing has been submitted, and provide them with the client ID number and authorization number of your authorization request. Please send the email to Nathaniel Thomas at nthomas@dmh.lacounty.gov; and copy James Spallino at jspallino@dmh.lacounty.gov, Elhi Saucedo at esaucedo@dmh.lacounty.gov, and Becky Pang at bpang@dmh.lacounty.gov.

13. CAU will approve the authorization request once it receives notification from you. After approval of the authorization request, CAU will notify you via email as well, and you may then move forward with submitting your test claim for that particular client.

The undersigned client or responsible adult consents to and authorizes over-threshold services provided by _____, and

has received a signed copy of the Over-threshold Authorization Request form.

_____	_____	_____
Print Client Name	Signature of Client	Date

_____	_____	_____
Print Name of Responsible Adult	Signature of Responsible Adult	Date

[PLEASE ATTACH THIS PAGE TO PRINTOUT OF OTAR FORM]